

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 2 & 7 will be 391 7 26 67 kk

09671

CERTIFICATE OF DEATH

09676

1. PLACE OF DEATH a. COUNTY <u>Potomac Valley N. H. County</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Michigan</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		d. STREET ADDRESS <u>7881 Van Dyke Place</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Herbert E. Adams</u>		4. DATE OF DEATH Month <u>July</u> Day <u>7</u> Year <u>1967</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 13, 1891</u>	9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Accounting</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>	
13. FATHER'S NAME <u>Henry Adams</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>374-16-3082</u>		17. INFORMANT <u>Betty Berry</u> Address <u>Red Barn La., Potomac, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4201</u> IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u> DUE TO (b) <u>Atherosclerotic Heart Disease</u> DUE TO (c) <u>Coronary Artery Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u> <u>unknown</u> <u>unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary Emphysema & Fibrosis; Chronic Bronchitis</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1967</u> to <u>7-7-</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 30, 1967</u> , and that death occurred at <u>2 P</u> M, from causes on and on the date stated above.					
22a. SIGNATURE <u>Francis J. Murray</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-7-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANCIS J. MURRAY</u>		22d. ADDRESS <u>1601 18th St NW Wash DC 20009</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>July 13, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Elmwood Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Detroit, Michigan</u>		
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>BETHESDA, MARYLAND</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u>



1005

April 13, 1941

Mr. J. Edgar Hoover

Washington, D.C.

Dear Mr. Hoover:

Enclosed for you are two copies of a letterhead memorandum (LHM) dated and captioned as above.

Very truly yours,

W. J. Clegg

WJ Clegg

100-100000

Very truly yours,

W. J. Clegg

Special Agent in Charge

Enclosure

100-100000

COOPER, John baby, Jr. registered

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09672

CERTIFICATE OF DEATH

09677

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SILVER SPRING c. LENGTH OF STAY IN 1b 151 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOLY CROSS HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY MONTGOMERY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE d. STREET ADDRESS 11424 SCHUYLKILL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DOROTHY A ALVANOS		4. DATE OF DEATH Month Day Year 7 12 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/18/92
9. AGE (In years lost birthday) yrs. 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) UNEMPLOYED	
11. BIRTHPLACE (County & State, or foreign country) NEW JERSEY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ERNST GENTZEL		14. MOTHER'S MAIDEN NAME XXXXXXXXXX Dora Schoeler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO.		16. SOCIAL SECURITY NO. 579-32-9922	
17. INFORMANT DAUGHTER: DOROTHY PELUSO		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Bilateral necrotizing lobar pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 4 days (c) INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) leukemia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour :o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July 11, 1967 , to July 12, 1967 , that (I) (we) last saw the deceased alive on July 12, 1967 , and that death occurred at 5 P. M. from causes and on the date stated above.			
22a. SIGNATURE Stephen Leventhal		22b. DATE SIGNED July 13, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. Stephen Leventhal, M.D.		22d. ADDRESS Silver Spring, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF 7/12/67	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill	23d. LOCATION (City or town) (County) (State) Prince George Co., Maryland
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1551 Rockville Pike		25a. REC'D BY REGISTRAR JUL 17 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

60072

MONTGOMERY

SILVER STRING

HOLY CROSS HOSPITAL - 1144 SCHUYLKILL

DOROTHY

A

ALANOS

7

12

FEMALE WHITE

X

2/11/92

22

EMPLOYED

ERST

GENTZEL

GENTZEL

NO

229-21-0001 DAUGHTER: DOROTHY PERKINS

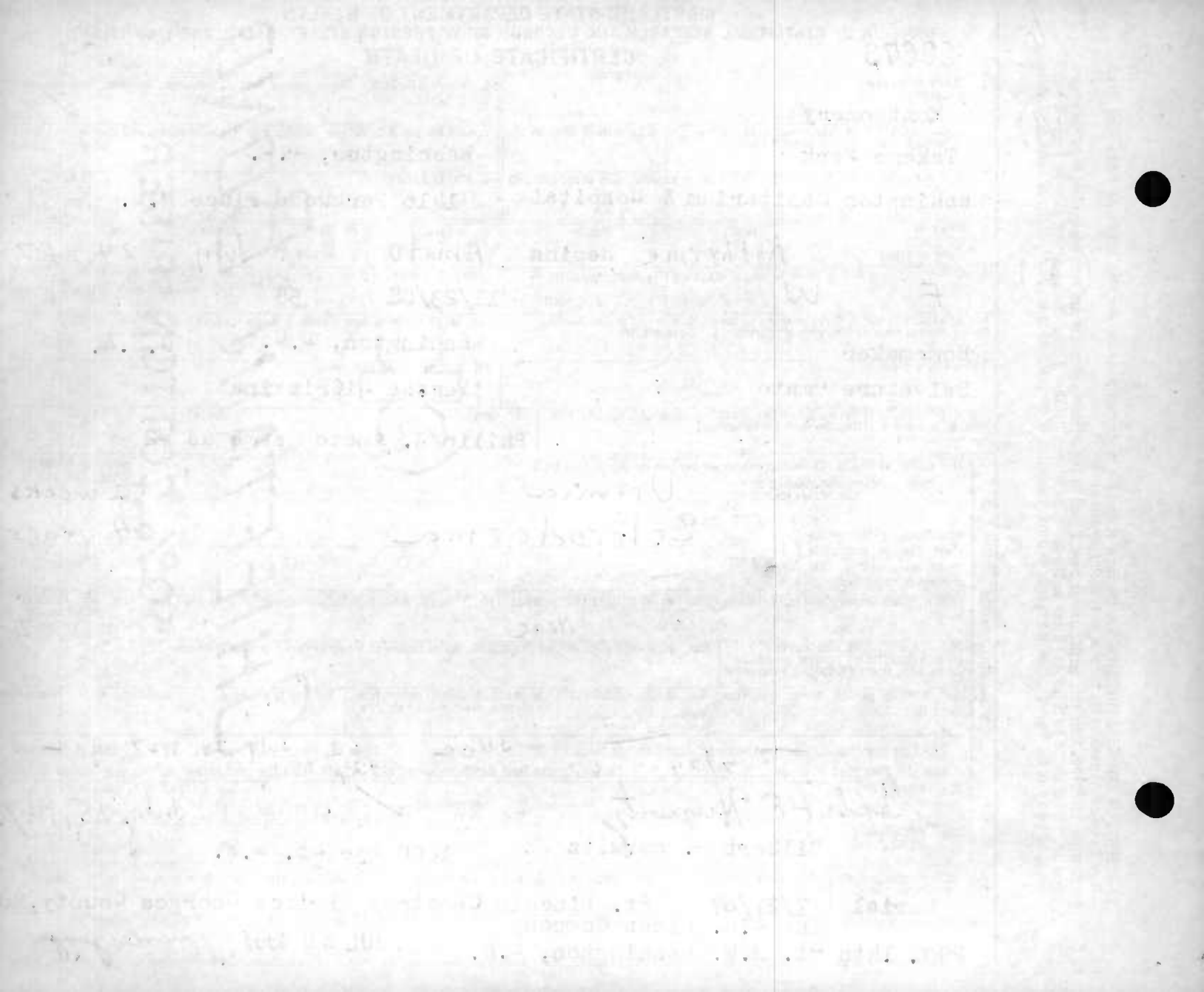
229-21-0001 DAUGHTER: DOROTHY PERKINS

229-21-0001 DAUGHTER: DOROTHY PERKINS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
09673 CERTIFICATE OF DEATH 09673									
1. PLACE OF DEATH a. COUNTY Montgomery b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium & Hospital					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE MARYLAND b. COUNTY Washington, D.C. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D.C. d. STREET ADDRESS 1416 Parkwood Place N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Katherine Middle Regina Last Amato					4. DATE OF DEATH Month July Day 24 Year 1967				
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/23/08		9. AGE (In years last birthday) 58 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Salvatore Amato					14. MOTHER'S MAIDEN NAME Teresa DiCristina				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Philip J. Amato same as #2				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Scleroderma DUE TO (c) —								INTERVAL BETWEEN ONSET AND DEATH 2 weeks 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from June , 1963, to July 24 , 1967, that (I) (we) last saw the deceased alive on 7/24 , 1967, and that death occurred at 4:20 p.m. from the causes and on the date stated above.									
22a. SIGNATURE Gilbert E. Hurwitz					22b. DATE SIGNED July 25, 1967			22c. PHYSICIAN'S NAME (Type) Gilbert E. Hurwitz	
22d. ADDRESS 1800 Eye St. N.W.									
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/27/67		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery			23d. LOCATION (City, town or county) (State) Prince Georges County, Md		
24. FUNERAL DIRECTOR The S.H. Hines Company 2901 14th St. N.W. Washington, D.C.					25a. REC'D BY REGISTRAR JUL 26 1967				
25b. REGISTRAR'S SIGNATURE Charles Judge									



09674

CERTIFICATE OF DEATH

09679

1. PLACE OF DEATH a. COUNTY MONTGOMERY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BETHESDA c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SUBURBAN				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE DISTRICT of Columbia b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 47.3 d. STREET ADDRESS 5000 MILLWOOD LANE N.W. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last JAFFA B. AWALT			4. DATE OF DEATH Month Day Year July 8 1967				
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/94	9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME GILBERT A. HASLUP				
14. MOTHER'S MAIDEN NAME ANNA M. TURNER			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W.I				
16. SOCIAL SECURITY NO. 579-60-9282			17. INFORMANT FRANCIS GLOYD AWALT, JR. Address 5000 MILLWOOD LANE N.W.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exsanguination due to varices 5810 DUE TO (b) Esophageal varices Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) Cirrhosis of the liver INTERVAL BETWEEN ONSET AND DEATH 4 days 6 yrs 12 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Apr , 19 61 , to July , 19 67 , that (I) we last saw the deceased alive on 7 July 1967 , and that death occurred at 7:45 A.M. , from causes and on the date stated above.					
22a. SIGNATURE Herbert Martyn Jr.			22b. DATE SIGNED 8 July 67		22c. PHYSICIAN'S NAME (Type) HERBERT MARTYN JR.		
22d. ADDRESS 4740 Chevy Chase Dr.			22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-11-1967		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat'l Cem.			
23d. LOCATION (City or Town) (County) (State) Arlington Va.		24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. DC.					
25a. REC'D BY REGISTRAR JUL 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

REPORT OF THE

5220

TO THE SECRETARY OF THE INTERIOR

FROM THE DIRECTOR OF THE BUREAU OF LAND MANAGEMENT

FOR THE YEAR 1952

AND FOR THE PERIOD FROM JANUARY 1, 1951, TO DECEMBER 31, 1952

IN ACCORDANCE WITH THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

AND THE REQUIREMENTS OF THE BUREAU OF LAND MANAGEMENT

AND THE REQUIREMENTS OF THE SECRETARY OF THE INTERIOR

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18&21 Film 391 8-3 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G391 7/31/67 ph

09675

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09680

1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY PRINCE GEORGE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY			c. LENGTH OF STAY IN 1b - DOA		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HYATTSVILLE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL D.O.A.				d. STREET ADDRESS 3904 NICHOLSON ST.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BRYANT Middle - Last BAGWELL				4. DATE OF DEATH Month 7 Day 24 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-26-05	
9. AGE (In years lost birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONSTRUCTION WORKER		11. BIRTHPLACE (State or foreign country) WAKE COUNTY, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARDY BAGWELL				14. MOTHER'S MAIDEN NAME ELLA SMITH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO 579 10 1853		17. INFORMANT MEDICAL RECORD DEPT. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary insufficiency with recent 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) and old myocardial infarction; DUE TO (c) Coronary artery heart disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							22. DATE SIGNED 7/24/1967
ACTUAL SIGNATURE Belden R. Reap, M.D.		EXAMINER'S NAME (Type) BELDEN R. REAP, M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED 7/24/1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 27, 1967		23c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery		23d. LOCATION (City or town) (County) (State) Colmar Manor, Prince George's Md.	
24. FUNERAL DIRECTOR F. Gasch's Sons Hyattsville, Md.				25a. RECEIVED BY REGISTRAR JUL 27 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

STANDARD RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

RECORDS

[Handwritten signature]

RECORDS

RECORDS

RECORDS

RECORDS

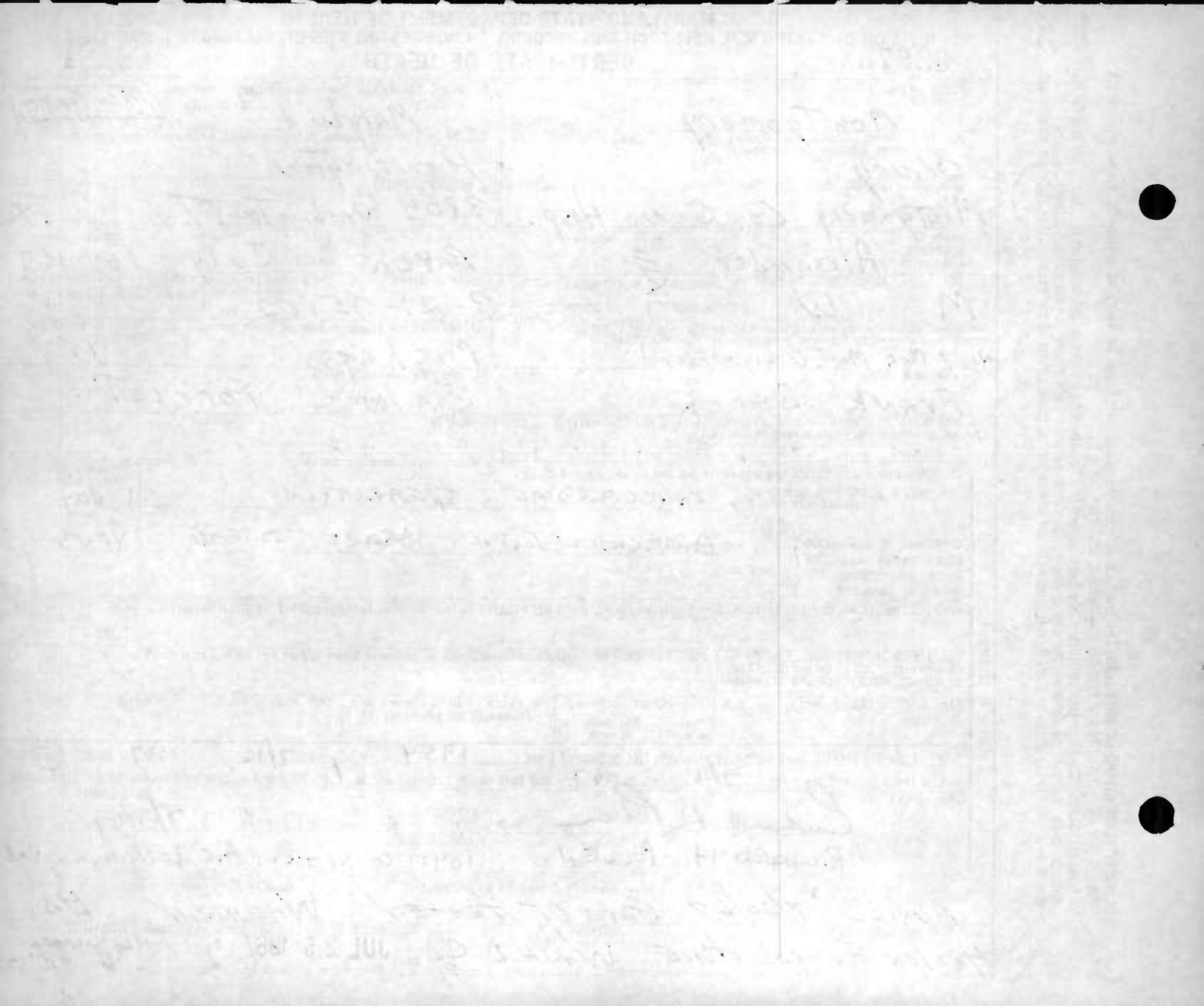
RECORDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09678 CERTIFICATE OF DEATH 09681

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kensington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Montgomery Co. Gen. Hosp.</u>				d. STREET ADDRESS <u>3804 Washington ST</u>			
3. NAME OF DECEASED (Type or print) <u>Alexander E. Barch</u>				4. DATE OF DEATH <u>July 16 1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-21-05</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Oays Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Mgr. Mont. Co. Liquor Board</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>MICHIGAN</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>Frank Barch</u>			
14. MOTHER'S MAIDEN NAME <u>Salome Forrest</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>YEARS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> , 19 <u>71</u> , to <u>7/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/16</u> , 19 <u>67</u> , and that death occurred at <u>6 P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Richard H. Pollen</u>				22b. DATE SIGNED <u>7/17/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN</u>				22d. ADDRESS <u>10400 CONNECTICUT AVE KENSINGTON, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/20/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u>		23d. LOCATION (City, town or county) (State) <u>WHEATON MD.</u>	
24. FUNERAL DIRECTOR <u>HANLON FUNERAL HOME</u>				25a. REC'D BY REGISTRAR <u>WASH. D. C.</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>JUL 25 1967</u>							



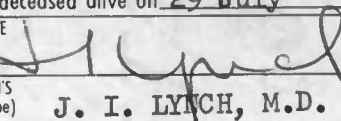
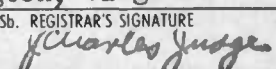
09677

CERTIFICATE OF DEATH

09682

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington D. C. b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda			c. LENGTH OF STAY IN lb 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) District of Columbia		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Naval Hospital				d. STREET ADDRESS 4605 47th Street, N.W.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lee Winthrop Barnes				4. DATE OF DEATH Month Day Year July 29 1967			
5. SEX Male	6. COLOR OR RACE Cauc	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 28 July 1967		9. AGE (In years lost birthday) yrs. 02		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Bethesda, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John W. Barnes Jr.				14. MOTHER'S MAIDEN NAME Patrica Ellen Davenport			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) None		16. SOCIAL SECURITY NO. None		17. INFORMANT John W. Barnes Jr. Washington, D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 28 July , 19 67 , to 29 July , 19 67 , that (X) (we) last saw the deceased alive on 29 July , 19 67 , and that death occurred at 5:30 PM , from causes and on the date stated above.							
22a. SIGNATURE 				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 31 July 1967	
22c. PHYSICIAN'S NAME (Type) J. I. LYNCH, M.D.				22d. ADDRESS Naval Hospital, Bethesda, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 8-1-67		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR R. A. Pumphrey				25a. REC'D BY REGISTRAR AUG 3 1967		25b. REGISTRAR'S SIGNATURE 	

STATE OF TEXAS

1902

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

San Antonio, Tex.

09678

CERTIFICATE OF DEATH

09683

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u>		d. STREET ADDRESS <u>12714 Fieldon ST</u>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>BARNWELL</u>		4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-67</u>
9. AGE (In years lost birthday) yrs. <u>6-58</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery--Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Vincent Barnwell</u>	
14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Vincent Barnwell-father-same item # 2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prenatal Neonatal Atelectasis</u> 7615 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity</u> DUE TO (c) <u>Premature rupture bag of waters</u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs 58 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE (CONDITION GIVEN IN PART I (a))		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 31, 1967</u> , to <u>JULY 31, 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 31, 1967</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Feroli</u>		22b. DATE SIGNED <u>7/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward Feroli, M.D.</u>		22d. ADDRESS <u>11250 Rockville Pike Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25. REC'D BY REGISTRAR <u>AUG 4 1967</u>	
25a. ADDRESS <u>1331 Rock. Pike Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0000

STATE OF OHIO

10

Infant

Non-Resident

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

Child

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div> <div>1</div> <div> <div>09679</div> <div>09684</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div>									
1. PLACE OF DEATH a. COUNTY MONTGOMERY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE N.J. b. COUNTY Bergen				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SPRINGFIELD			c. LENGTH OF STAY IN 1b 3 mos.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Wood-Ridge				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 5409 CHRISTY DR.					d. STREET ADDRESS 335 Columbia Blvd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARTHA Middle (NMI) Last BARRERE					4. DATE OF DEATH Month July Day 29 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 27, 1889		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) New York			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Antoine Lablanche					14. MOTHER'S MAIDEN NAME MARIE Forest				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes give war or dates of service) no		17. INFORMANT JOHN A. BARRERE - Wood-Ridge, N.J.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of pancreas 157X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease								INTERVAL BETWEEN ONSET AND DEATH 5 mo.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 62 , to July 29, 1967 , that (I) (we) last saw the deceased alive on July 29, 1967 , and that death occurred at 335 PM , from the causes and on the date stated above.									
22a. SIGNATURE C P Ryland					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) C P RYLAND					22d. ADDRESS 4400-4981 NW Wash DC 20016				
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 2 Aug 1967		23c. NAME OF CEMETERY OR CREMATORY Geo. WASH. Mem PK.			23d. LOCATION (City, town or county) (State) PARAMUS, N.J.		
24. FUNERAL DIRECTOR Joseph Gawlees Son's Inc. WASH. DC.					25a. REC'D BY REGISTRAR AUG 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

RECEIVED AT OFFICE

1987

AUG 2 1987

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

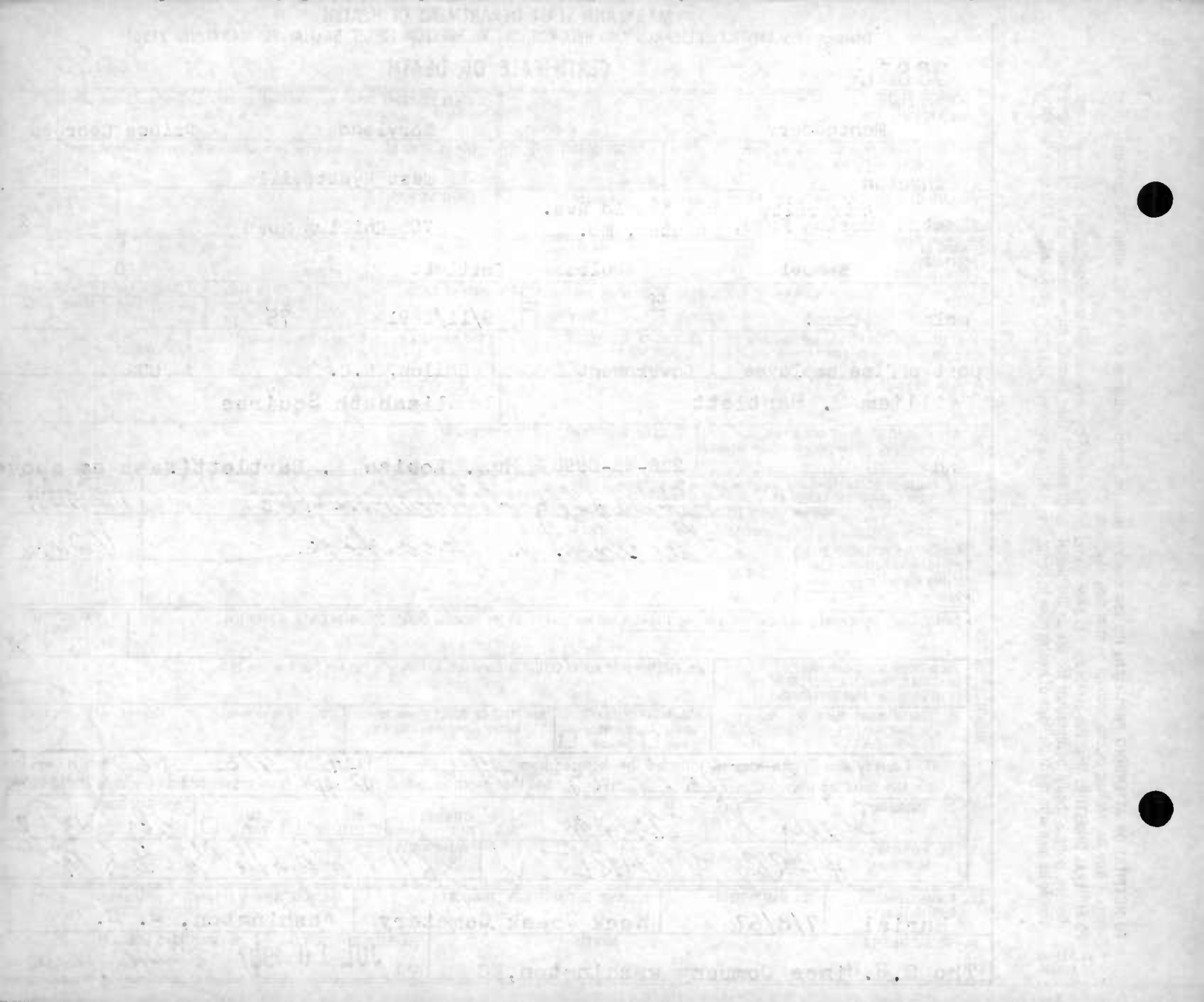
1
3
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09680

CERTIFICATE OF DEATH

09685

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince Georges	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton		c. LENGTH OF STAY IN 1b 16.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) University 901 Arcola Ave. Wheaton Nursing Home, Wheaton, Md.		d. STREET ADDRESS 705 Chillum Road	
3. NAME OF DECEASED (Type or print) Samuel Squires Bartlett		4. DATE OF DEATH Month 7 Day 6 Year 19 67	
5. SEX male	6. COLOR OR RACE Caus.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/11/1891
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) post office employee		10b. KIND OF BUSINESS OR INDUSTRY Government	9. AGE (In years last birthday) 75 yrs.
11. BIRTHPLACE (County & State, or foreign country) Shiloh, N.C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William S. Bartlett		14. MOTHER'S MAIDEN NAME Elizabeth Squires	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 226-48-0998A	
17. INFORMANT Mrs. Louise V. Bartlett (same as above)		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Sexualized Cancerous skin DUE TO (b) Carcinoma prostate DUE TO (c) 72mts. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 1 1/2 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 64 , to 7/6 , 19 67 that (I) (we) last saw the deceased alive on 7/5 , 19 67 , and that death occurred at 12:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Harry N. Carlton		22b. DATE SIGNED July 6, 1967	
22c. PHYSICIAN'S NAME (Type) HARRY N. CARLTON		22d. ADDRESS 8811 Coloma Rd - S.S. Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/8/67	23c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery	23d. LOCATION (City or Town) (County) (State) Washington, D. C.
24. FUNERAL DIRECTOR The S.H. Hines Company Washington, DC		25a. REC'D BY REGISTRAR DATE JUL 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in on the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09681

CERTIFICATE OF DEATH

09686

1. PLACE OF DEATH a. COUNTY Baltimore Montgomery MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE New Jersey b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda				c. LENGTH OF STAY IN 1b 13 Mos 29 days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BETHESDA NAVAL HOSPITAL				d. STREET ADDRESS 1320 Sayrs Ave.			
3. NAME OF DECEASED (Type or print) First Alfred Middle BASILE Last				4. DATE OF DEATH Month 7 Day 31 Year 67			
5. SEX Male		6. COLOR OR RACE Cauc		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 25 July 1916	
9. AGE (In years lost, birthday) yrs. 51		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.S. Air Force				10b. KIND OF BUSINESS OR INDUSTRY Military		11. BIRTHPLACE (County & State, or foreign country) NEW YORK N.Y.	
13. FATHER'S NAME FRANK BASILE				14. MOTHER'S MAIDEN NAME THERESA BRANCO			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes UNKNOWN				16. SOCIAL SECURITY NO. 155-05-2020		17. INFORMANT Thomas Basile 162 Haddon Ave. New, Jersey	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of base of Tongue DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with metastases DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1 June , 19 66 , to 31 July , 19 67 , that (I) (we) last saw the deceased alive on 31 July 19 67 , and that death occurred at 215P M, from causes and on the date stated above.							
22a. SIGNATURE H.O. Defries				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1 Aug 1967	
22c. PHYSICIAN'S NAME (Type) H.O. Defries				22d. ADDRESS Naval Hospital, Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 AUGUST 1967		23c. NAME OF CEMETERY OR CREMATORY Harleigh, Camden, N.J.		23d. LOCATION (City or Town) (County) (State) Camden, New Jersey	
24. FUNERAL DIRECTOR Joseph Bocco, Camden, New Jersey				25a. REC'D BY REGISTRAR AUG 2 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

NEW YORK STATE OF NEW YORK

1932

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09682

09687

1. PLACE OF DEATH a. COUNTY Montgomery MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington D.C. b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park		c. LENGTH OF STAY IN lb 22 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Sanitarium and Hospital		d. STREET ADDRESS 1125 Spring Road	
3. NAME OF DECEASED (Type or print) Sarah (none) Becker		4. DATE OF DEATH Month July Day 20 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-22-98
9. AGE (In years last birthday) yrs. 68		10. IF UNDER 1 YEAR Months 20 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laundry Worker		10b. KIND OF BUSINESS OR INDUSTRY Russia	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 577-05-8648	
17. INFORMANT Patient's chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X Central thrombosis DUE TO Generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) year (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-28-67 , 19 67 , to 7-20 , 19 67 , that (I) (we) last saw the deceased alive on 7-19 , 19 67 , and that death occurred at 2:45 A.M., from causes and on the date stated above.			
22a. SIGNATURE Abraham W. Danis		22b. DATE SIGNED 7-20-67	
22c. PHYSICIAN'S NAME (Type) ABRAHAM W. DANIS		22d. ADDRESS 1106 SPRING ST. S.E. MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7-21-67	
23c. NAME OF CEMETERY OR CREMATORY CHESED SHEL EMMES CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON D. C.	
24. FUNERAL DIRECTOR Frederick J. ...		25a. REC'D BY REGISTRAR DATE JUL 24 1967	
25b. REGISTRAR'S SIGNATURE Charles ...			

CERTIFICATE OF DEATH

1900

Full name of deceased

Age

Sex

Color

Place of birth

Usual residence

Occupation

Education

Marital status

Religion

Signature of physician

Signature of registrar

Witness

Signature of informant

Date

Time

Place

Signature of informant

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>CALIFORNIA</u> b. COUNTY <u>LOS ANGELES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAND CHASE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERKELEY</u>	
c. LENGTH OF STAY IN 1b <u>5/1/67-7-30-67</u>		d. STREET ADDRESS <u>649. S. BUENOSIDE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BETHESDA SILVER SPRING NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Last, Middle First <u>BERBERICK, BARC JESSIE</u>		4. DATE OF DEATH Month Day Year <u>7 30 1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT 23, 88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>House wife</u>	9. AGE (In years last birthday) yrs. <u>78</u>
13. FATHER'S NAME <u>GUSTAVE BERBER</u>		14. MOTHER'S MAIDEN NAME <u>BEILA BACK BACK</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>509-03-6663-D</u>	
17. INFORMANT <u>BETTY FREDERICK</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>January, 1967</u> , to <u>7/30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/30</u> , 19 <u>67</u> , and that death occurred at <u>3P</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7/30/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>BLAINE H BIG</u>		22d. ADDRESS <u>1641 Colver Rd Silver Spring, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
<u>BURIAL</u>	<u>Aug-67</u>	<u>ROSE HILL Cem.</u>	<u>CHICAGO. ILL.</u>
24. FUNERAL DIRECTOR <u>Bessley Home</u>		25a. REC'D BY REGISTRAR <u>4217 9-200</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>AUG 1 1967</u>	

MEDICAL CERTIFICATION

20180

RECEIVED BY

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900. 901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000. 1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100. 1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200. 1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300. 1301. 1302. 1303. 1304. 1305. 1306. 1307. 1308. 1309. 1310. 1311. 1312. 1313. 1314. 1315. 1316. 1317. 1318. 1319. 1320. 1321. 1322. 1323. 1324. 1325. 1326. 1327. 1328. 1329. 1330. 1331. 1332. 1333. 1334. 1335. 1336. 1337. 1338. 1339. 1340. 1341. 1342. 1343. 1344. 1345. 1346. 1347. 1348. 1349. 1350. 1351. 1352. 1353. 1354. 1355. 1356. 1357. 1358. 1359. 1360. 1361. 1362. 1363. 1364. 1365. 1366. 1367. 1368. 1369. 1370. 1371. 1372. 1373. 1374. 1375. 1376. 1377. 1378. 1379. 1380. 1381. 1382. 1383. 1384. 1385. 1386. 1387. 1388. 1389. 1390. 1391. 1392. 1393. 1394. 1395. 1396. 1397. 1398. 1399. 1400. 1401. 1402. 1403. 1404. 1405. 1406. 1407. 1408. 1409. 1410. 1411. 1412. 1413. 1414. 1415. 1416. 1417. 1418. 1419. 1420. 1421. 1422. 1423. 1424. 1425. 1426. 1427. 1428. 1429. 1430. 1431. 1432. 1433. 1434. 1435. 1436. 1437. 1438. 1439. 1440. 1441. 1442. 1443. 1444. 1445. 1446. 1447. 1448. 1449. 1450. 1451. 1452. 1453. 1454. 1455. 1456. 1457. 1458. 1459. 1460. 1461. 1462. 1463. 1464. 1465. 1466. 1467. 1468. 1469. 1470. 1471. 1472. 1473. 1474. 1475. 1476. 1477. 1478. 1479. 1480. 1481. 1482. 1483. 1484. 1485. 1486. 1487. 1488. 1489. 1490. 1491. 1492. 1493. 1494. 1495. 1496. 1497. 1498. 1499. 1500. 1501. 1502. 1503. 1504. 1505. 1506. 1507. 1508. 1509. 1510. 1511. 1512. 1513. 1514. 1515. 1516. 1517. 1518. 1519. 1520. 1521. 1522. 1523. 1524. 1525. 1526. 1527. 1528. 1529. 1530. 1531. 1532. 1533. 1534. 1535. 1536. 1537. 1538. 1539. 1540. 1541. 1542. 1543. 1544. 1545. 1546. 1547. 1548. 1549. 1550. 1551. 1552. 1553. 1554. 1555. 1556. 1557. 1558. 1559. 1560. 1561. 1562. 1563. 1564. 1565. 1566. 1567. 1568. 1569. 1570. 1571. 1572. 1573. 1574. 1575. 1576. 1577. 1578. 1579. 1580. 1581. 1582. 1583. 1584. 1585. 1586. 1587. 1588. 1589. 1590. 1591. 1592. 1593. 1594. 1595. 1596. 1597. 1598. 1599. 1600. 1601. 1602. 1603. 1604. 1605. 1606. 1607. 1608. 1609. 1610. 1611. 1612. 1613. 1614. 1615. 1616. 1617. 1618. 1619. 1620. 1621. 1622. 1623. 1624. 1625. 1626. 1627. 1628. 1629. 1630. 1631. 1632. 1633. 1634. 1635. 1636. 1637. 1638. 1639. 1640. 1641. 1642. 1643. 1644. 1645. 1646. 1647. 1648. 1649. 1650. 1651. 1652. 1653. 1654. 1655. 1656. 1657. 1658. 1659. 1660. 1661. 1662. 1663. 1664. 1665. 1666. 1667. 1668. 1669. 1670. 1671. 1672. 1673. 1674. 1675. 1676. 1677. 1678. 1679. 1680. 1681. 1682. 1683. 1684. 1685. 1686. 1687. 1688. 1689. 1690. 1691. 1692. 1693. 1694. 1695. 1696. 1697. 1698. 1699. 1700. 1701. 1702. 1703. 1704. 1705. 1706. 1707. 1708. 1709. 1710. 1711. 1712. 1713. 1714. 1715. 1716. 1717. 1718. 1719. 1720. 1721. 1722. 1723. 1724. 1725. 1726. 1727. 1728. 1729. 1730. 1731. 1732. 1733. 1734. 1735. 1736. 1737. 1738. 1739. 1740. 1741. 1742. 1743. 1744. 1745. 1746. 1747. 1748. 1749. 1750. 1751. 1752. 1753. 1754. 1755. 1756. 1757. 1758. 1759. 1760. 1761. 1762. 1763. 1764. 1765. 1766. 1767. 1768. 1769. 1770. 1771. 1772. 1773. 1774. 1775. 1776. 1777. 1778. 1779. 1780. 1781. 1782. 1783. 1784. 1785. 1786. 1787. 1788. 1789. 1790. 1791. 1792. 1793. 1794. 1795. 1796. 1797. 1798. 1799. 1800. 1801. 1802. 1803. 1804. 1805. 1806. 1807. 1808. 1809. 1810. 1811. 1812. 1813. 1814. 1815. 1816. 1817. 1818. 1819. 1820. 1821. 1822. 1823. 1824. 1825. 1826. 1827. 1828. 1829. 1830. 1831. 1832. 1833. 1834. 1835. 1836. 1837. 1838. 1839. 1840. 1841. 1842. 1843. 1844. 1845. 1846. 1847. 1848. 1849. 1850. 1851. 1852. 1853. 1854. 1855. 1856. 1857. 1858. 1859. 1860. 1861. 1862. 1863. 1864. 1865. 1866. 1867. 1868. 1869. 1870. 1871. 1872. 1873. 1874. 1875. 1876. 1877. 1878. 1879. 1880. 1881. 1882. 1883. 1884. 1885. 1886. 1887. 1888. 1889. 1890. 1891. 1892. 1893. 1894. 1895. 1896. 1897. 1898. 1899. 1900. 1901. 1902. 1903. 1904. 1905. 1906. 1907. 1908. 1909. 1910. 1911. 1912. 1913. 1914. 1915. 1916. 1917. 1918. 1919. 1920. 1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

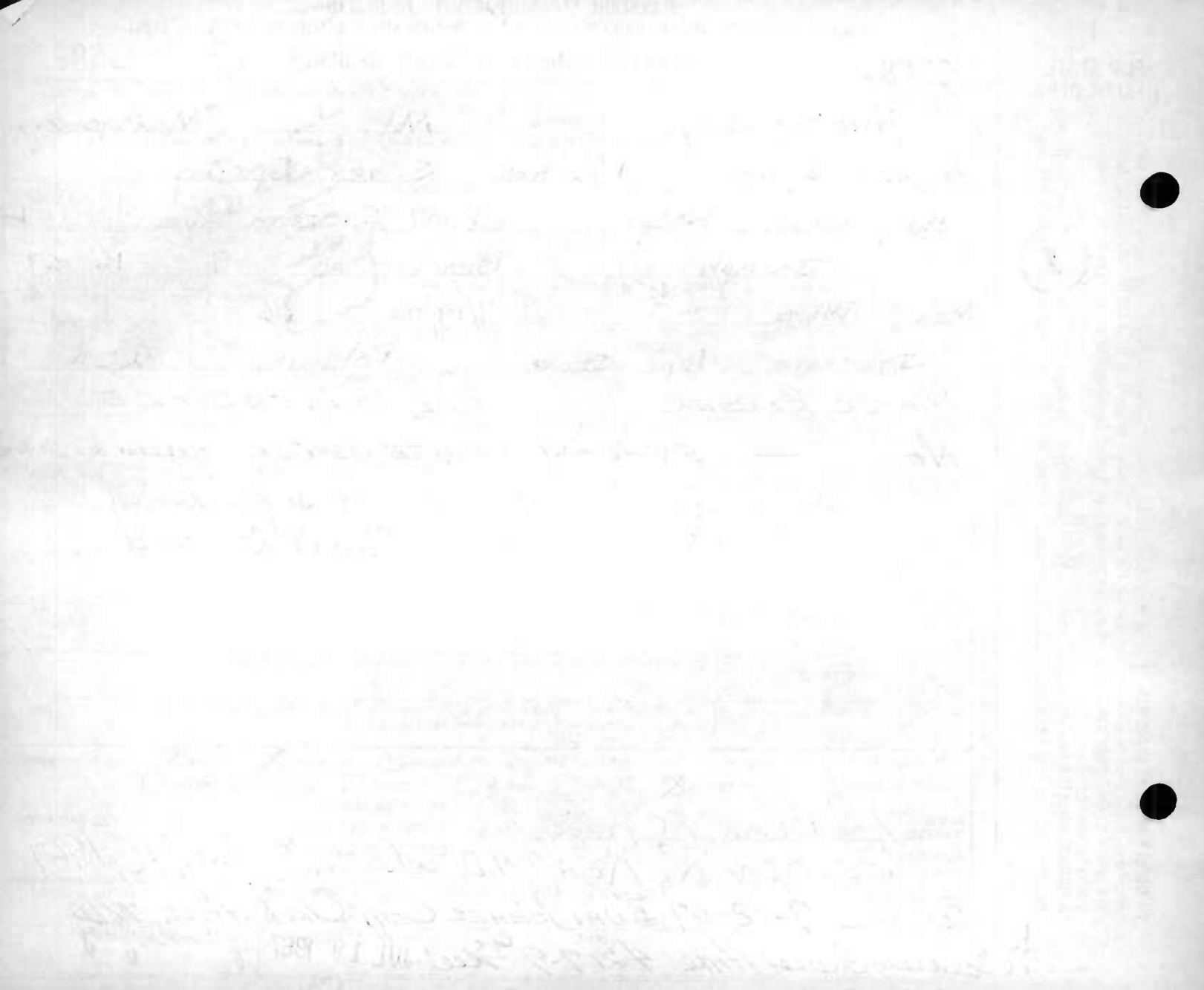
09689

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE MD. b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN lb
1 1/2 hrs | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hosp. | | d. STREET ADDRESS
8007 Eastern Ave | |
| 3. NAME OF DECEASED (Type or print)
First Joseph Middle Berger Last Berger | | 4. DATE OF DEATH
Month 7 Day 16 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/19/00 |
| 9. AGE (In years last birthday)
66 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 16 Hours 16 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Salesman | | 10b. KIND OF BUSINESS OR INDUSTRY
Dept. Store | |
| 11. BIRTH PLACE (State or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
MAYER BERGER | | 14. MOTHER'S MAIDEN NAME
KAE SILVERSTONE | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
578-46-4321 | |
| 17. INFORMANT
CHARLOTTE BERGER | | Address
(same as 2nd) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO (b) Coronary Artery Heart Disease
DUE TO (c) Coronary Artery Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Belden R. Neap M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) BELDEN R. NEAP M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED July 16, 1967 | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7-18-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY BNAI ISRAEL Cem | | 23d. LOCATION (City or town) (County) (State) OXON HILL, MD. | |
| 24. FUNERAL DIRECTOR Goodley Funeral Home | | 25a. REC'D BY REGISTRAR JUL 19 1967 | |
| 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09685

09690

| | | | | | | | |
|--|--|--|--|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>10607 Kenilworth Ave. Apt. 203</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Apartment # 203</u> | | | | d. STREET ADDRESS
<u>Bethesda, Md.</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Charles Kingsman Berlin</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>16</u> Year <u>1967</u> | | | |
| 5. SEX
<u>M</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 14, 1898</u> | |
| 9. AGE (In years last birthday)
<u>69</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Insurance-Comptroller-Gov't-Retired</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Washington, D. C.</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>William B. Berlin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary Elizabeth Clements</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>Yes WW I</u> | | | | 16. SOCIAL SECURITY NO. <u> </u> | | | |
| 17. INFORMANT
<u>wife</u> | | | | Address <u>Same as Item 2.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial failure</u>
<u>53W</u> DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>Chronic emphysema</u>
DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>None</u> | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
<u>None</u> | | | |
| 20c. TIME OF INJURY
Month, Day, Year
<u>July 16, 1967</u> | | 20d. INJURY OCCURED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> to <u>present</u> , that (I) (we) last saw the deceased alive on <u>May 19, 1967</u> , and that death occurred at <u>11:15</u> M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>John B. Umhau</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>7/16/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN B. UMHAU</u> | | | | 22d. ADDRESS
<u>8805 CONN. AVE. CHEVY CHASE</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7-19-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | 23d. LOCATION (City, town or county) (State)
<u>Washington, D. C.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | | 25. REC'D BY REGISTRAR
<u>JUL 19 1967</u> | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | |

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 Carver notified & approved.

10
1

James B. Thompson

7283

1 day 10007 Kumbura Ave.
Baltimore, Md.

Charles K. Thompson

May 10, 1908

Insurance - Corporation of Baltimore
New York City

Wife: Helen M. Thompson

Myocardial failure
Chronic emphysema

None

None

~~10007 Kumbura Ave.~~

John B. Thompson
May 10

10007 Kumbura Ave.

8800 Conn Ave

ROBERT A. FARMER, Bethesda, Maryland
JUL 19 1908
Rock Creek Cemetery, Washington, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09686

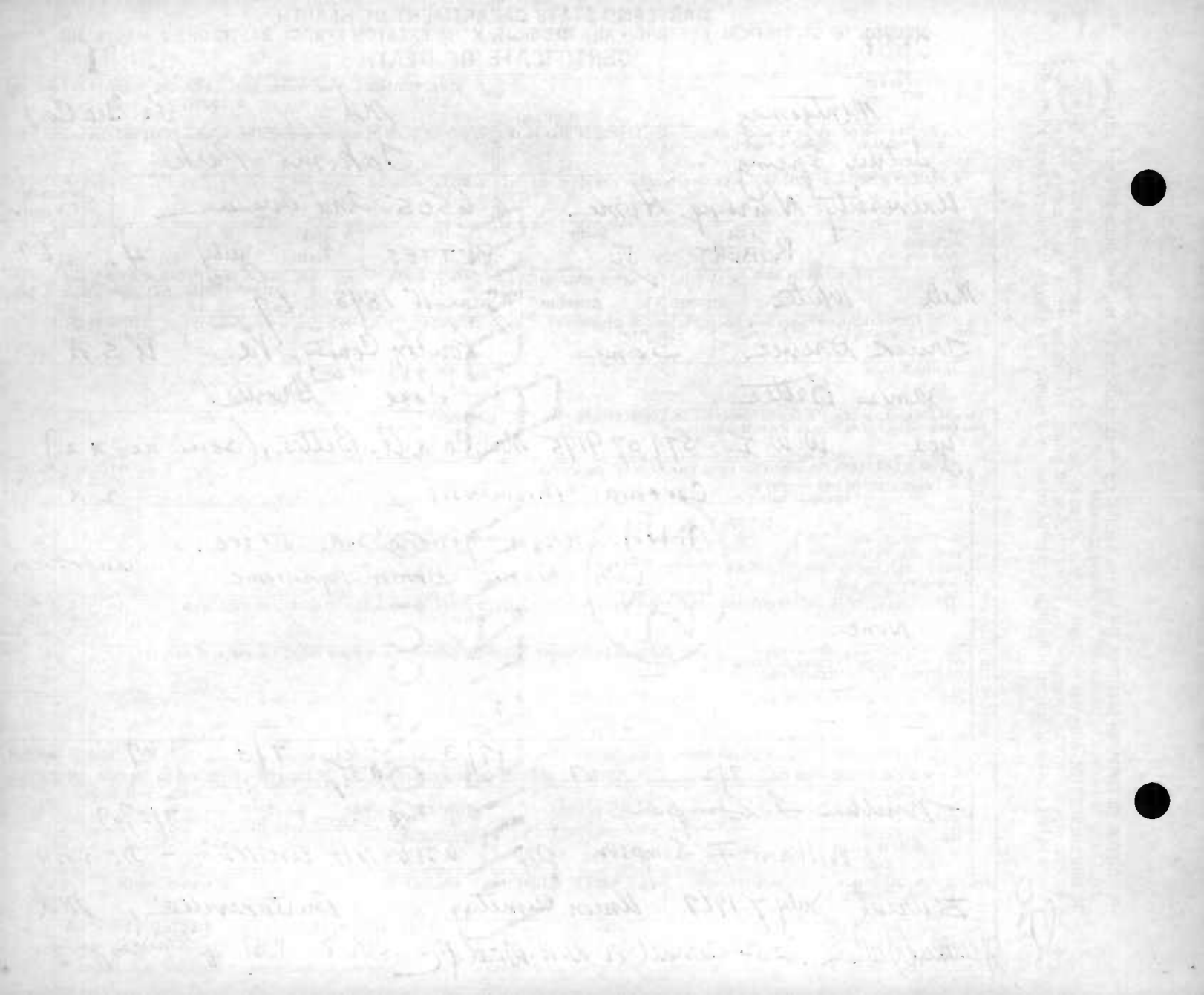
STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09691

| | | | | | | | |
|---|-------------------------------|---|---------------------------------------|--|-----------------------------|--|-----------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Pr. Geo. Co.</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home</u> | | | | d. STREET ADDRESS <u>6505 2nd Avenue</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>J.</u> Last <u>BETTES</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>4</u> Year <u>1967</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>June 16, 1898</u> | 9. AGE (in years last birthday) <u>69</u> yrs. | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Driver</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>London County, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>James Bettes</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sara Groves</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | 16. SOCIAL SECURITY NO. <u>W.W.I</u> | | 17. INFORMANT <u>Mrs. Cora A. Bettes, (same as #2)</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
332x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, generalized, severe,</u>
DUE TO (c) <u>with chronic brain syndrome</u>
undeterm. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. — p.m. — 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/3</u> , 19 <u>67</u> to <u>7/4</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/2</u> , 19 <u>67</u> , and that death occurred at <u>1:35</u> M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>William F. Simpson</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>7/5/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>William F Simpson, MD</u> | | | | 22d. ADDRESS <u>6246 NH Ave NE - DC 20011</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | |
| <u>Burial</u> | | <u>July 7, 1967</u> | | <u>Union Cemetery</u> | | <u>Burtonsville, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Arthur Walters, 254 Carroll St N.W. Wash DC</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Jones</u> | |



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09687

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09692

| | | | | | |
|--|----------------------------------|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓
a. STATE
Maryland
b. COUNTY
Howard | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
DOA | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural Simpsonville 13.2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General | | | d. STREET ADDRESS
Rt. 32 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
Lewis Royal Boardley | | | 4. DATE OF DEATH
Month 7 Day 22 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/15/1896 | 9. AGE (In years lost birthday)
70 yrs. | IF UNDER 1 YEAR
Months 7 Days 22
IF UNDER 24 HRS.
Hours 19 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Gardener | | 10b. KIND OF BUSINESS OR INDUSTRY
Landscaping | | 11. BIRTHPLACE (State or foreign country)
Maryland | |
| 13. FATHER'S NAME
unknown | | | 14. MOTHER'S MAIDEN NAME
Bell Boardley | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
220-30-3115 | | 17. INFORMANT
Medical Records of Montg. General Hospt. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Insufficiency
DUE TO (b) Coronary Artery Heart Disease
DUE TO (c) Coronary Artery Heart Disease
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | M.D.
BELDEN R. REAP, M.D. | | 22. DATE SIGNED
7/23/1967 | |
| EXAMINER'S NAME (Type)
BELDEN R. REAP | | Address (State, city or town or county)
Rockville, Md. | | | |
| 23a. BURIAL, CREMATION REMOVAL
BURIAL | | 23b. DATE THEREOF
7-25-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Hopkins Church, | |
| 23d. LOCATION (City or town)
Highland, Md. | | (County) | | (State) | |
| 24. FUNERAL DIRECTOR
Robert L. Snowden. | | ADDRESS
Rockville, Md. | | 25a. REC'D BY REGISTRAR
DATE JUL 24 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

30782

187



... ..

... ..

... ..

... ..

... ..

... ..

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
20M 1/65

| MONTGOMERY STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------------------|--|---|--|--|--|---|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery
5714 UNIVERSITY BLVD EAST MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Washington, b. COUNTY D.C. | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Silver Spring, Md. | | | | | | c. LENGTH OF STAY IN 1b
2 Yrs. | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Bella Vista Nursing Home | | | | | | d. STREET ADDRESS
5821 14th St. N.W. | | | | | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Frances Middle Brooksie Last Brooksie | | | | 4. DATE OF DEATH
Month JULY Day 8 Year 1967 | | | | | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
DEC 3, 1888 | | 9. AGE (In years last birthday)
78 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSE WIFE | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | | 11. BIRTHPLACE (County & State, or foreign country)
Broad Creek MD | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
James R Edelen | | | | | | 14. MOTHER'S MAIDEN NAME
Mary Rober MD | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | | | 16. SOCIAL SECURITY NO.
577-07-8984B | | 17. INFORMANT
Mr J Arthur Brooksie | | | | Address
5821 14th St N.W. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Vascular Accident
33IX
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cerebral Atherosclerosis
DUE TO
(c) Acute Congestive Heart Failure | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 wks | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Senility | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from Apr 30, 1962 to July 8, 1967 , that (I) (we) last saw the deceased alive on July 8, 1967 , and that death occurred at 7:48 M , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Philip E. Jones | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
7/8/67 | | | |
| 22c. PHYSICIAN'S NAME (Type)
Philip E. Jones MD | | | | | | 22d. ADDRESS
800 Pershing Alpine Silver Spring Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
7-11-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City, town or county) (State)
Washington, D.C. | | | |
| 24. FUNERAL DIRECTOR
A. Huntemann & Son Funeral Home | | | | ADDRESS
5732 Georgia Ave N.W. | | 25a. REC'D BY REGISTRAR
JUL 12 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

843-844

010 79901-00 AD

1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Signed with permission of Dr. Paul - Crowner

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
09689 CERTIFICATE OF DEATH 09694

| | | | | | | | |
|--|----------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i> | | MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
b. STATE
<i>Maryland</i> | | c. COUNTY
<i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | c. LENGTH OF STAY IN 1b
<i>2 hrs</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | <i>154</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>Holy Cross Hospital</i> | | d. STREET ADDRESS
<i>1810 Arcola Avenue</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Eva</i> Middle <i>Sarah</i> Last <i>Brown</i> | | 4. DATE OF DEATH
Month <i>July</i> Day <i>19</i> Year <i>1967</i> | | | | | |
| 5. SEX
<i>female</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>Aug 26, 1897</i> | 9. AGE (In years last birthday)
<i>69 yrs.</i> | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Own home</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Washington, D. C.</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Charles Hulien</i> | | 14. MOTHER'S MAIDEN NAME
<i>Minnie Lerch</i> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>None</i> | | 17. INFORMANT
<i>Mrs. Thelma Woodson</i> | | Address
<i>1810 Arcola Avenue Silver Spring, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
<i>4201</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Chronic Cardio-Vascular Nephro-</i>
(c) <i>Sclerosis</i> | | INTERVAL BETWEEN ONSET AND DEATH
<i>2 hours</i>
<i>24 years</i> | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Diabetes</i> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>Feb</i> | | 20f. (City or town) (County) (State)
<i>50</i> <i>11 July 67</i> | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Feb</i> , 19 <i>50</i> , to <i>11 July</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>11 July</i> , 19 <i>67</i> , and that death occurred at <i>7:57 PM</i> , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Robert C. Haile</i> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>July 19, 1967</i> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Robert C. Haile, M. D.</i> | | 22d. ADDRESS
<i>8209 Kerry Road, Chevy Chase, Maryland</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>July 22, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rock Creek Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Washington D. C.</i> | |
| 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i> | | ADDRESS
<i>434 Georgia Avenue Silver Spring, Md.</i> | | 25a. REC'D BY REGISTRAR
<i>JUL 24 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

STATE OF NEW YORK
IN SENATE
January 10, 1967
REPORT OF THE
COMMISSIONER OF THE
DEPARTMENT OF
CORRECTIONS
AND
JUVENILE JUSTICE
ON THE
ADMINISTRATIVE
AND
FINANCIAL
OPERATIONS OF THE
DEPARTMENT
FOR THE
FISCAL YEAR
ENDING
JUNE 30, 1966
ALBANY: J.B. LIPPINCOTT COMPANY, 1967
PUBLISHED BY THE
J.B. LIPPINCOTT COMPANY
ALBANY, NEW YORK
1967
100-100000-100000

09695

09690

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN 1b <u>4 hrs 55 mins</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
d. STREET ADDRESS <u>13601 Hoyola St.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Genevieve Marshall Brown</u>
First Middle Last
4. DATE OF DEATH <u>July 5 1967</u>
Month Day Year | | 5. SEX <u>Female</u>
6. COLOR OR RACE <u>White</u>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>8/1/05</u>
9. AGE (In years last birthday) <u>61</u>
10. UNDER 1 YEAR <input type="checkbox"/> 11. UNDER 24 HRS. <input type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Analyst</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | 13. FATHER'S NAME <u>Charles H. Marshall</u>
14. MOTHER'S MAIDEN NAME <u>Thelma Sargent</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>
16. SOCIAL SECURITY NO. <u>Yes</u>
17. INFORMANT <u>Charles Brown</u>
1801 Hoyola St. Silver Spring, Md. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic carcinoma breast</u>
DUE TO <u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>18 yrs</u>
DUE TO (c) <u>18 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour "o.m." p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>7/4</u> , 1967, that (I) (we) last saw the deceased alive on <u>1 July</u> , 1967, and that death occurred on <u>5/6/67</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Horace W. Bernton</u>
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. PHYSICIAN'S NAME (Type) <u>Horace W. Bernton</u>
22d. ADDRESS <u>4743 Bradley Blvd., Ch. Ch., Md.</u> | | 22b. DATE SIGNED <u>7/5/67</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 8, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Park</u> | 23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u>
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>
DATE | 25b. REGISTRAR'S SIGNATURE <u>Charles J. Juge</u> |

10001
10002
10003
10004
10005
10006
10007
10008
10009
10010
10011
10012
10013
10014
10015
10016
10017
10018
10019
10020
10021
10022
10023
10024
10025
10026
10027
10028
10029
10030
10031
10032
10033
10034
10035
10036
10037
10038
10039
10040
10041
10042
10043
10044
10045
10046
10047
10048
10049
10050
10051
10052
10053
10054
10055
10056
10057
10058
10059
10060
10061
10062
10063
10064
10065
10066
10067
10068
10069
10070
10071
10072
10073
10074
10075
10076
10077
10078
10079
10080
10081
10082
10083
10084
10085
10086
10087
10088
10089
10090
10091
10092
10093
10094
10095
10096
10097
10098
10099
10100

10001
10002
10003
10004
10005
10006
10007
10008
10009
10010
10011
10012
10013
10014
10015
10016
10017
10018
10019
10020
10021
10022
10023
10024
10025
10026
10027
10028
10029
10030
10031
10032
10033
10034
10035
10036
10037
10038
10039
10040
10041
10042
10043
10044
10045
10046
10047
10048
10049
10050
10051
10052
10053
10054
10055
10056
10057
10058
10059
10060
10061
10062
10063
10064
10065
10066
10067
10068
10069
10070
10071
10072
10073
10074
10075
10076
10077
10078
10079
10080
10081
10082
10083
10084
10085
10086
10087
10088
10089
10090
10091
10092
10093
10094
10095
10096
10097
10098
10099
10100

10001
10002
10003
10004
10005
10006
10007
10008
10009
10010
10011
10012
10013
10014
10015
10016
10017
10018
10019
10020
10021
10022
10023
10024
10025
10026
10027
10028
10029
10030
10031
10032
10033
10034
10035
10036
10037
10038
10039
10040
10041
10042
10043
10044
10045
10046
10047
10048
10049
10050
10051
10052
10053
10054
10055
10056
10057
10058
10059
10060
10061
10062
10063
10064
10065
10066
10067
10068
10069
10070
10071
10072
10073
10074
10075
10076
10077
10078
10079
10080
10081
10082
10083
10084
10085
10086
10087
10088
10089
10090
10091
10092
10093
10094
10095
10096
10097
10098
10099
10100

09691

CERTIFICATE OF DEATH

09696

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
c. LENGTH OF STAY IN lb
31 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium and Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
d. STREET ADDRESS
7667 Maple Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
James Alton Bruen, Sr. | | 4. DATE OF DEATH
Month Day Year
7-21-67
19 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-11-04 |
| 9. AGE (In years last birthday)
63 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Stock Broker Vice President | | 10b. KIND OF BUSINESS OR INDUSTRY
Floegel, Nolan, Fleming & Co. New York | |
| 11. BIRTHPLACE (County & State, or foreign country)
America | | 12. CITIZEN OF WHAT COUNTRY?
America | |
| 13. FATHER'S NAME
Edward Bruen | | 14. MOTHER'S MAIDEN NAME
Grace Reynolds | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
579-01-9162 | |
| 17. INFORMANT
Patient's Chart | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinosis of the Liver with Hepatic Coma
5810 DUE TO Asplenik
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute
DUE TO Hypochromic anemia
(c) Anemia | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Congestive Heart Failure (mild), Esophageal Varices, Aortic Stenosis | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 6-20 , 1967, to 7-21 , 1967, that (I) (we) last saw the deceased alive on 7-21 , 1967, and that death occurred at 6:25 AM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Alan R. Gair | | 22b. DATE SIGNED
7/21/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Alan R. Gair M.D. | | 22d. ADDRESS
7777 Maple Ave, Takoma Park, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | 23b. DATE THEREOF
7/24/67 | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. |
| 24. FUNERAL DIRECTOR
The S.H. Hines Company
2901 14th St. N.W. Wash. D.C. | | 25a. REC'D BY REGISTRAR
JUL 24 1967
25b. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1000

CERTIFICATE OF DEATH

1000

County

County

County

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

09692

CERTIFICATE OF DEATH

09697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|-------------------------------------|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
OLNEY
c. LENGTH OF STAY IN lb
13 DAYS | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY HOWARD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
ELLICOTT CITY
13.2
d. STREET ADDRESS
RT#2, TRIDELPHIA ROAD
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First GEORGE Middle ANDER Last BURGESS | | | 4. DATE OF DEATH
Month JULY Day 27 Year 1967 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
NEGRO | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
11/1/02 | 9. AGE (In years lost birthday)
64 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY
FARMER | | 11. BIRTHPLACE (County & State, or foreign country)
MARYLAND | |
| 13. FATHER'S NAME
FRANK BURGESS | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
MEDICAL RECORDS
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, INSTANTANEOUS
4201 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
LEFT CEREBRAL THROMBOSIS WITH RIGHT HEMIPLEGIA-13 DAYS DURATION | | | | | INTERVAL BETWEEN ONSET AND DEATH
15 MIN. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/4/1962 , 19____, to____, 19____, that (I) (we) last saw the deceased alive on JULY 27 19 67 , and that death occurred at 9:30AM , from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<i>Charles S. Whitaker, M.D.</i> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
JULY 27, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
CHARLES S. WHITAKER, M.D. | | | 22d. ADDRESS
ELLICOTT CITY, MARYLAND | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | 23b. DATE THEREOF
7/30/67 | 23c. NAME OF CEMETERY OR CREMATORY
BR OWNS CHAPEL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
DAYTON, HOWARD, MD. | |
| 24. FUNERAL DIRECTOR
<i>Robert L. Snowden</i>
ROCKVILLE, MD. | | | 25a. REC'D BY REGISTRAR
DATE AUG 4 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> |

1999

50 Y. Liu

044.9647 : 710-73071 : 35

10. 11. 1991

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09693

CERTIFICATE OF DEATH

09693

| | | | | | | | | |
|--|--|---|--|---|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | | c. LENGTH OF STAY IN 1b | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Brookeville | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General Hospital | | | | d. STREET ADDRESS | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print) George Albert Burroughs | | | | 4. DATE OF DEATH
Month July Day 22 Year 1967 | | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-17-89 | | |
| 9. AGE (In years last birthday) yrs. 77 | | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
District Gov. | | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
George E. Burroughs | | | | 14. MOTHER'S MAIDEN NAME
Barbara Peters | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
212-10-3922 | | 17. INFORMANT
Medical Records Address Montgomery Gen. Hospital | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of pancreas
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
6 months | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Feb 1860 to July 22, 1967 , that (I) (we) lost saw the deceased alive on July 21, 1967 , and that death occurred at 6:30am M, from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
A.D. Bonifant | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | |
| 22c. PHYSICIAN'S NAME (Type) Dr. A.D. Bonifant | | | | 22d. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-24-67 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Carmel | | 23d. LOCATION (City or Town) (County) (State)
Sunshine, Md | | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Funeral Home | | | | 25a. REC'D BY REGISTRAR
DATE JUL 25 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6883

DEPARTMENT OF DEATH

Heiried

Glacier Hwy.

315-10-3385

no

Domestic, no

Mr. Canal

70-12-1

Partial

JUL 2 1987

James H. Barker Federal House
Lawtonville, Mo.

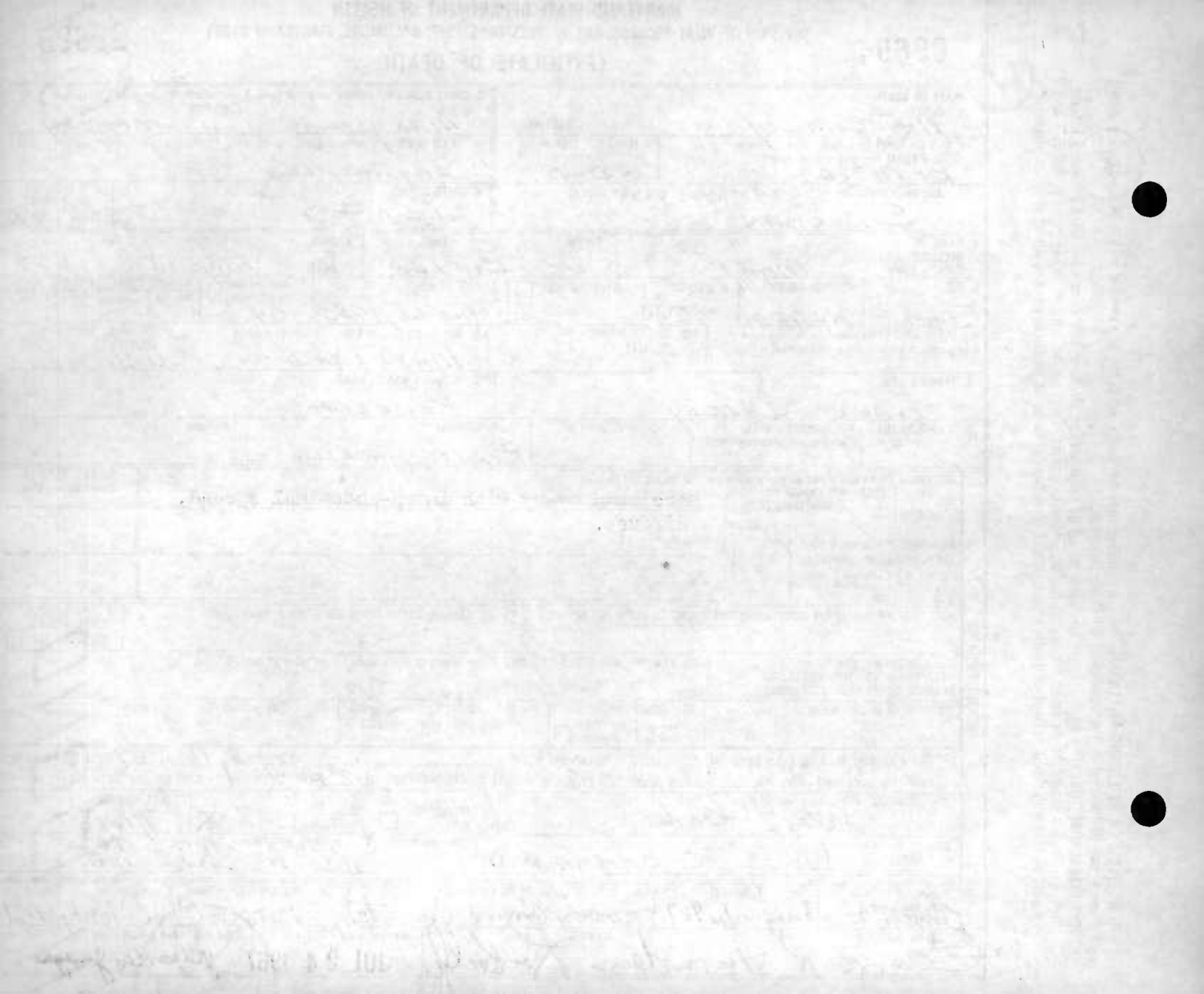
CERTIFICATE OF DEATH

09694

09699

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | c. LENGTH OF STAY IN lb <u>3 DAYS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u> | | d. STREET ADDRESS <u>R.F.D. # 2</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>JANE</u> Last <u>BUTLER</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>18</u> Year <u>1967</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>NEGRO</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUNE 26, 1903</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>FRANK DOBSEY</u> | | 14. MOTHER'S M maiden NAME <u>REBECCA</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>BERNICE JACKSON</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma ovary with intra-abdominal spread,</u>
<u>1750</u> DUE TO <u>diffuse.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that the (this hospital) attended the deceased from <u> </u> , 19 <u> </u> to <u>July 18, 1967</u> , that it (we) last saw the deceased alive on <u>July 18, 1967</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above | | | |
| 22a. SIGNATURE <u>Jules I. Cahan</u> M.D. | | 22b. DATE SIGNED <u>7/19/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>JULES I. CAHAN, M.D.</u> | | 22d. ADDRESS <u>SUBURBAN HOSP BETHESDA MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>July 21, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Emory Grove Montg, Md</u> |
| 24. FUNERAL DIRECTOR <u>George R. Snowden</u> | | 25. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| 25a. REC'D BY REGISTRAR <u>Lockwell</u> | | DATE <u>JUL 24 1967</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the funeral papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09695

09700

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D. C.</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b
<u>22 days/7 hours</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium & Hospital</u> | | | | d. STREET ADDRESS
<u>2853 Ontario Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Edwin</u> First <u>(None)</u> Middle <u>Butterworth</u> Last | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>29</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>3-3-87</u> | |
| 9. AGE (In years last birthday)
<u>80</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired Minister</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Clergy</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Pa.</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | 13. FATHER'S NAME
<u>Edwin Butterworth</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Mary Mac Caloup</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>578-50-5201</u> | | | | 17. INFORMANT
<u>Marion Beebe</u> Address <u>2853 Ontario Rd. N. W.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> | | | | | | | |
| DUE TO (b) <u>Arteriosclerotic heart disease</u> years | | | | | | | |
| DUE TO (c) <u>Arteriosclerosis obliterans</u> years | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>History of tuberculosis in youth - treated</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> <u>19</u> p.m. | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | (County) | | (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1967</u> to <u>July 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 22, 1967</u> , and that death occurred <u>10:30 P.</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Kenneth Cruze</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>July 30, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Kenneth Cruze</u> | | | | 22d. ADDRESS
<u>831 University Blvd. E., Silver Spring, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Trans-Burial</u> | | 23b. DATE THEREOF
<u>Aug. 3, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Philipsburg Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Philipsburg, Pennsylvania</u> | |
| 24. FUNERAL DIRECTOR
<u>Glen Carter</u> | | | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| 26. DATE
<u>AUG 1 1967</u> | | | | 27. ADDRESS
<u>Warner E. Pumphrey, Inc. 8434 Georgia Ave. Silver Spring, Md.</u> | | | |

72852

Montgomery

Takoma Park

Washington, D.C.

Female

White

Weight 11.5 lbs

Edwin Butterworth

No.

D.C.

Washington, D.C.

2122 Ontario Rd.

Home/Work

July 28

3-3-79

May 1981

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

212-2221 Hospital Records

09696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09701

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1055 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| c. LENGTH OF STAY IN 1b - <u>8 yr</u> | | d. STREET ADDRESS <u>9602 Bulls Run Pky</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9602 Bulls Run Pky</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Bonnie Cora Compagna</u> | | 4. DATE OF DEATH <u>July 24 1967</u> | |
| 5. SEX <u>Fe</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 17 1952</u> |
| 9. AGE (In years last birthday) <u>15</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>Joseph H. Compagna</u> | | 14. MOTHER'S MAIDEN NAME <u>Eileen Bryson</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>974X</u> IMMEDIATE CAUSE (a) <u>Strangulation</u>
DUE TO (b) <u>Hanging</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hung self on door with bed sheet.</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>7:30 p.m. July 24 1967</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) (County) (State) <u>Bethesda Mont. Md.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>7/24/67</u> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u> | 23b. DATE THEREOF <u>7-26-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u> |
| 24. FUNERAL DIRECTOR ADDRESS <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>JUL 28 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

1771

0000

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

1771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

09697

5 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09702

| | | | |
|---|----------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN lb
5 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General Hospital | | d. STREET ADDRESS
Park Avenue | |
| 3. NAME OF DECEASED (Type or print)
Dolly | | 4. DATE OF DEATH
Month July Day 8 Year 19 67 | |
| 5. SEX
female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/ /91 |
| 9. AGE (In years last birthday) yrs.
76 | | 10. BIRTHPLACE (County & State, or foreign country)
Maryland | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
unknown | | 14. MOTHER'S MAIDEN NAME
unknown | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
unknown | | 16. SOCIAL SECURITY NO.
unknown | |
| 17. INFORMANT
Montgomery General Hospital records | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1538
IMMEDIATE CAUSE (a) Toxemia
DUE TO (b) Intestinal Obstruction
DUE TO (c) Adenocarcinoma, Colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
10 days | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/13 1967 to 7/8 1967 , that (I) (we) last saw the deceased alive on 7/7 1967 , and that death occurred 12:27 P. from causes on and on the date stated above. | | 22a. SIGNATURE
Charles H. Ligon, M.D. | |
| 22b. DATE SIGNED
7/8/67 | | 22c. PHYSICIAN'S NAME (Type)
Charles H. Ligon, M.D. | |
| 22d. ADDRESS
Sandy Spring, Md. | | 22e. REC'D BY REGISTRAR
JUL 12 1967 | |
| 22f. REGISTRAR'S SIGNATURE
Charles Judge | | 22g. DATE
JUL 12 1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
7/11, 67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
LINCOLN PARK | | 23d. LOCATION (City or Town) (County) (State)
ROCKVILLE, MONTG. MD. | |
| 24. FUNERAL DIRECTOR
H. L. Snowden | | 25. ADDRESS
ROCKVILLE, MD. | |

80

CERTIFICATE OF DEATH

1914

[Faint, mostly illegible text in the main body of the form, likely containing personal and medical details.]

ROCKVILLE, MONTGOMERY CO., MD.

LINCOLN PARK

1914

DEATH

ROCKVILLE, MD.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09698

09703

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Bethesda</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda M.D.A.</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bowie</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | d. STREET ADDRESS <u>3048 - Traymore Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Raymond Campbell Carleton</u> | | | | 4. DATE OF DEATH <u>July 31 1967</u> | | | |
| 5. SEX <u>male</u> | | 6. COLOR OR RACE <u>white</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 17/1931</u> | |
| 9. AGE (In years last birthday) <u>36</u> yrs. | | 10. UNDER 1 YEAR <input type="checkbox"/> Months <input type="checkbox"/> Days <input type="checkbox"/> Min. | | 11. BIRTHPLACE (State or foreign country) <u>Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>British</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service manager</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Shop</u> | | | |
| 13. FATHER'S NAME <u>James Carleton</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Elsie Lingwall</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> | | | | 16. SOCIAL SECURITY NO. <u>219-38-6903</u> | | 17. INFORMANT <u>Cecil Norman Bowditch</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Injuries, multiple, severe.</u>
DUE TO (b) <u>Auto accident</u>
DUE TO (c) <u>8164</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Drive car. thru stop street. struck by oncoming car.</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>4 45 p.m. 7/31 1967</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> | | | | 20f. (City or town) <u>Bethesda Mont.</u> (County) <u>Md.</u> (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Aug 1, 1967</u> | | | |
| | | | | Address (Street, city, town, or county) | | | |
| 23a. CREMATION <input checked="" type="checkbox"/> | | 23b. DATE THEREOF <u>8/3/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u> | | 23d. LOCATION (City or Town) <u>Suitland</u> (County) <u>Md.</u> (State) | |
| 24. FUNERAL DIRECTOR <u>Ritchie Bros. Fun'l Home-Maryland.</u> | | | | 25a. REC'D BY REGISTRAR <u>Aug 4 1967</u> | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

100

MENTAL EXAMINING CERTIFICATE OF STATE

100

Shop

Shop

100

MENTAL EXAMINING CERTIFICATE OF STATE

MENTAL EXAMINING CERTIFICATE OF STATE

John C. Bell, M.D.

ON EXAMINATION
MAKING

8/2/67

Godar Hill Cemetery, Scotland

Alcoholic Prod., Small Home-Made, and
Liquor, Wapiti, and

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|--|---|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 09699 | | | | | | | | | |
| 09704 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b <u>7 DAYS</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | | 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u> | | | | | d. STREET ADDRESS <u>205 S. WASHINGTON ST</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>ETHEL R. CARR</u> | | | | | 4. DATE OF DEATH Month Day Year <u>July 14 1967</u> | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>12/4/82</u> | | 9. AGE (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. <u>7 10</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TELEPHONE OPERATOR</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>COURT HOUSE - ROCKVILLE</u> | | | 11. BIRTHPLACE (County & State, or foreign country) <u>Rockville, MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JACOB POSS</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>APOLONIA DODSON</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>APOLONIA E. MONDAY - NIECE - 5. SPRING</u> Address <u>4412 Bennion Rd</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Congestive Heart Failure</u>
DUE TO (b) <u>Recent Myocardial Infarct</u>
DUE TO (c) <u>Coronary Arteriosclerosis</u> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1-3 wks</u>
<u>20-50 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebrovascular disease</u> | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE <u>Jay R. Shapiro</u> M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Jay R. Shapiro</u> | | | | | 22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/19/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Rockville, Maryland</u> | | |
| 24. FUNERAL DIRECTOR ADDRESS <u>Tyson Wheeler Funeral Home 1331 Rock. Pike Rockville, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR DATE <u>JUL 18 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

1914
CERTIFICATE OF DEATH

2218 Madison Ave., Hoboken, N.J.

Hoboken, N.J.

1914

1914

From the office of the Registrar of the City of Hoboken, N.J.
1914

09700

CERTIFICATE OF DEATH

09705

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE West Virginia b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
5 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First H. Middle Hobart Last Carrico | | 4. DATE OF DEATH
Month July Day 13 Year 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 3, 1897 |
| 9. AGE (In years lost birthday)
70 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Technician (Retired) | |
| 11. BIRTHPLACE (County & State, or foreign country)
West Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Joseph Carrico | | 14. MOTHER'S MAIDEN NAME
Mary Britten | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
Yes WW I | | 16. SOCIAL SECURITY NO.
WW I | |
| 17. INFORMANT
Lula Craig Carrico | | Address
Morgantown, W. Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 331X
DUE TO Cerebral Hemorrhage
(b) Generalized Arteriosclerosis
DUE TO Years
(c) Healed Myocardial Infarction | | | INTERVAL BETWEEN ONSET AND DEATH
5 days |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Healed Myocardial Infarction | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/8/67 , to 7/13/67 , that (I) (we) last saw the deceased alive on 7/13/67 , and that death occurred at 3:54 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John J. Curry | | 22b. DATE SIGNED
7/13/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John J. Curry | | 22d. ADDRESS
10620 Georgia Ave | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7/15/67 | 23c. NAME OF CEMETERY OR CREMATORY
Maple Grove Cemetery | 23d. LOCATION (City or town) (County) (State)
Kingwood W. Va. |
| 24. FUNERAL DIRECTOR
R.V. Murphy | | 25a. REC'D BY REGISTRAR
JUL 17 1967 | |
| ADDRESS
Funeral Home | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| Arlington, Va. | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF DEATH

1911

West Virginia

County

Washington

Age

Single

112 Harrison Avenue

High Cross Hospital

July

Division

Report

in

10

April 3, 1911

White

Male

Wm. H. Hays, West Virginia

(Resident of)

Harry Hays

Joseph Hays

112 Harrison Avenue, West Virginia

Wm

Ym

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

112 Harrison Avenue

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office, along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09701

09706

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1823 Avenel Road</u> | | d. STREET ADDRESS <u>1823 Avenel Road</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Julian Robert Carter</u> | | 4. DATE OF DEATH <u>7</u> Month <u>12</u> Year <u>1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-30-22</u> 44 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u> | |
| 13. FATHER'S NAME <u>John R. Carter</u> | | 14. MOTHER'S MAIDEN NAME <u>Kate Francis</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>232-30-8154</u> | |
| 17. INFORMANT <u>FAMILY</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Sunshot wound, left</u>
DUE TO (b) <u>Chest, with exsanguination</u>
DUE TO (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased, depressed, shot self in chest</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>9:30 am 7-12-1967</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Woods</u> | 20f. (City or town) <u>Silver Spring</u> (County) <u>Montgomery</u> (State) <u>MD</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>7-12-1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (street, city, town, or county) <u>Silver Spring</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 16, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Draper Cemetery</u> | 23d. LOCATION (City or Town) <u>Draper</u> (County) <u>North Carolina</u> (State) <u></u> |
| 24. FUNERAL DIRECTOR <u>W. W. Chambers Co., Silver Spring Md</u> | | 25a. REC'D BY REGISTRAR <u>JUL 17 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

3 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the tab papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09702

CERTIFICATE OF DEATH

09707

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Springs</u> | |
| c. LENGTH OF STAY IN 1b <u>4 days</u> | | d. STREET ADDRESS <u>12516 Denley Rd.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Bernard Wheeler Clark</u> | | 4. DATE OF DEATH <u>July 11 1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-3-99</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>?</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Thomas Clark</u> | | 14. MOTHER'S MAIDEN NAME <u>Margaret Wheeler</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>578-68-0753</u> | |
| 17. INFORMANT <u>Washington Sanitarium</u> | | Address <u>Takoma Park, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aspiration</u>
<u>199.2</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Cerebral & Cerebral</u>
DUE TO
(c) <u>Carcinoma of Pelvis & Neopharynx</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/7</u> , 19 <u>67</u> , to <u>7/11</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/10</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>R. Merrel Olsen</u> | | 22b. DATE SIGNED <u>7/11/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>R. MERREL OLSEN, M.D.</u> | | 22d. ADDRESS <u>831 University Blvd, Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>JULY 13 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>GLENWOOD CEM</u> | 23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u> |
| 24. FUNERAL DIRECTOR <u>W.W. Chambers</u> | | 25a. REC'D BY REGISTRAR <u>SILVER SPRING MD</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>JUL 14 1967</u> | |

REPORT OF THE

1911

THE ATTORNEY GENERAL
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
ON JANUARY 10, 1911
RELATIVE TO THE
ADMINISTRATION OF THE
OFFICE OF THE ATTORNEY GENERAL
DURING THE YEAR 1910

THE OFFICE OF THE ATTORNEY GENERAL
HAS THE HONOR TO ACKNOWLEDGE
THE RECEIPT OF THE REPORT
OF THE ATTORNEY GENERAL
FOR THE YEAR 1910
AND TO STATE THAT THE
SAME HAS BEEN
FILED IN THE OFFICE OF THE
ATTORNEY GENERAL
AND THAT THE
SAME IS AVAILABLE FOR
PUBLIC INSPECTION
AT THE OFFICE OF THE
ATTORNEY GENERAL
AND AT THE
LIBRARY OF THE
STATE OF NEW YORK

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

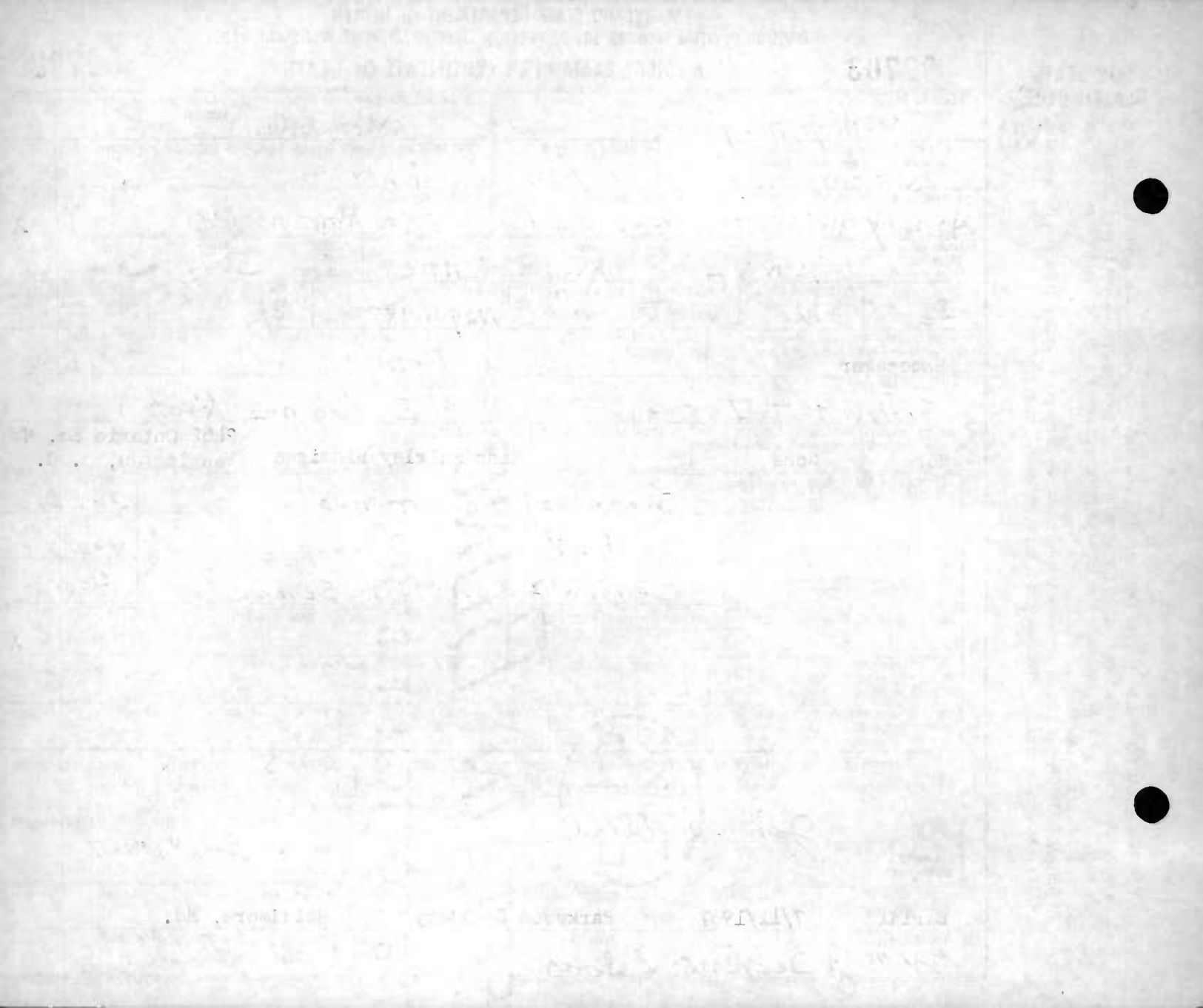
VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|---|
| 09703 | | 09708 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>-</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Galithersburg</u> | c. LENGTH OF STAY IN lb
<u>16 years</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Baltimore</u> 30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Asbury Methodist Home for aged</u> | | d. STREET ADDRESS
<u>6 St. Martin's Rd</u> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First <u>ANNA</u> Middle <u>May</u> Last <u>Cline</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>8</u> Year <u>1967</u> | |
| 5. SEX <u>Fe.</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 11, 1873</u> 94 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday)
<u>94</u> yrs. |
| 11. BIRTHPLACE (State or foreign country)
<u>Penn.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Gilbert T. Israel</u> | | 14. MOTHER'S MAIDEN NAME
<u>E. Virginia Keeton</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Miss Shirley Biddison</u> | | 2102 Ontario Rd. NW
Washington, D. C. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>4221</u> IMMEDIATE CAUSE (a) <u>Bronchial Pneumonia</u>
DUE TO (b) <u>Cardio Vascular Disease</u>
DUE TO (c) <u>Generalized Arterio Sclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>years</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>John B. Bell</u> M.D. | | 22. DATE SIGNED
<u>July 8, 1967</u> | |
| EXAMINER'S NAME (Type)
<u>John B. Bell</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>7/11/1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parkwood Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Wm J. Duckner & Sons</u> | | 25. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

25. REC'D BY REGISTRAR
DATE JUL 11 1967



09704

CERTIFICATE OF DEATH

09709

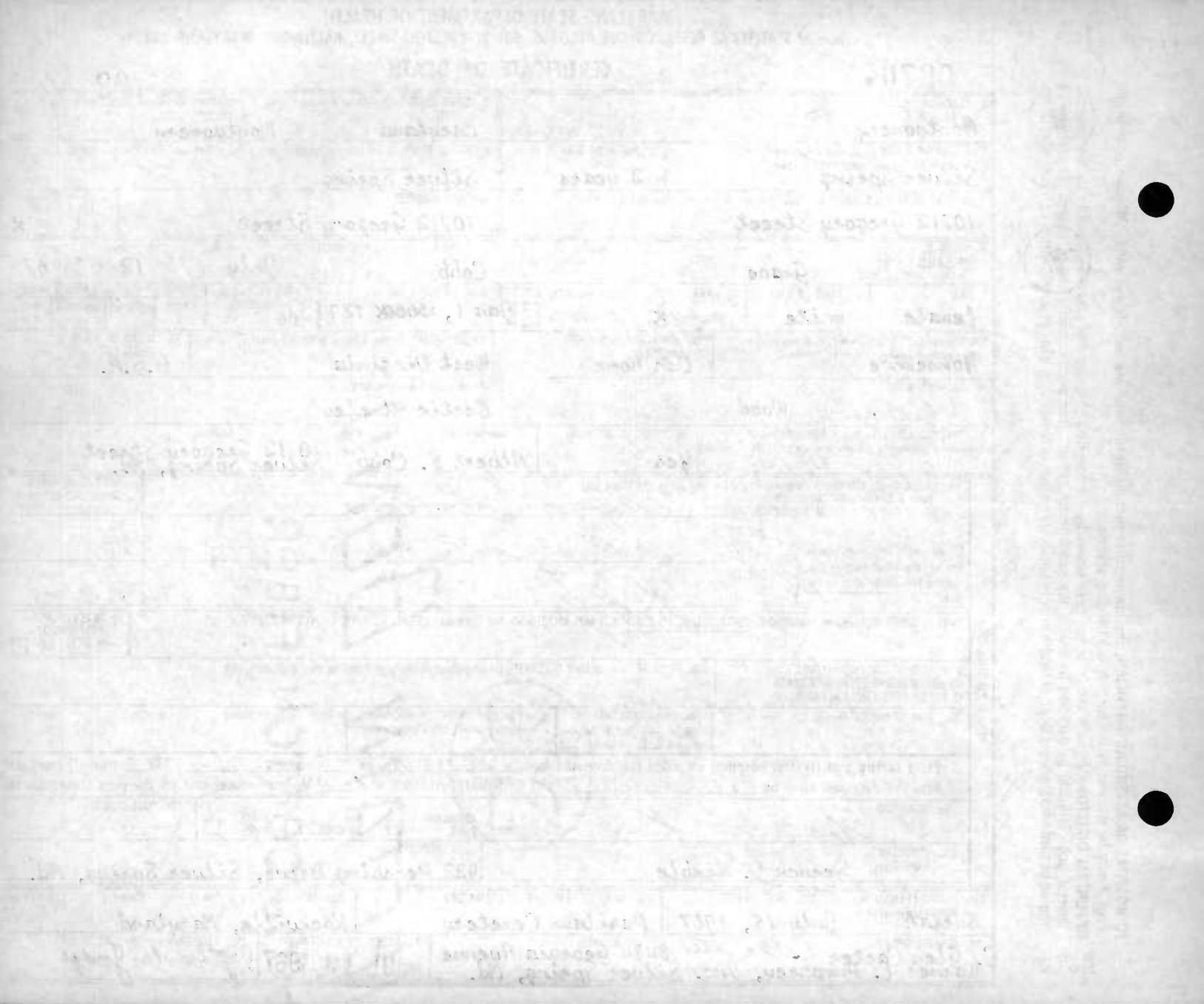
| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN lb
<u>2 years</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>10712 Gregory Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Grace Cobb</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>12</u> Year <u>19 67</u> | |
| 5. SEX
<u>female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan 1, 1899</u> |
| 9. AGE (In years last birthday) yrs. <u>68</u> | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>West Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>(Unknown) Wood</u> | | 14. MOTHER'S MAIDEN NAME
<u>Bertie Plumley</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>No</u> <u>NONE</u> | | 16. SOCIAL SECURITY NO.
<u>Yes</u> | |
| 17. INFORMANT
<u>Albert B. Cobb</u> | | Address
<u>10712 Gregory Street Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>332X</u> IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>
DUE TO (c) <u>Hypertension</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>5 months</u>
<u>5 years</u>
<u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>12 March, 19 65</u> to <u>12 July, 1967</u> , that (I) <u>was</u> last saw the deceased alive on <u>10 March 1967</u> , and that death occurred at <u>8 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Serach T. Kimble</u> | | 22b. DATE SIGNED
<u>7-12-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Serach J. Kimble</u> | | 22d. ADDRESS
<u>922 Pershing Drive, Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>July 15, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Glen Carter, Glen Carter & Son, Inc., 8434 Georgia Avenue, Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 19 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

Medical Certification

OP - cleared by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

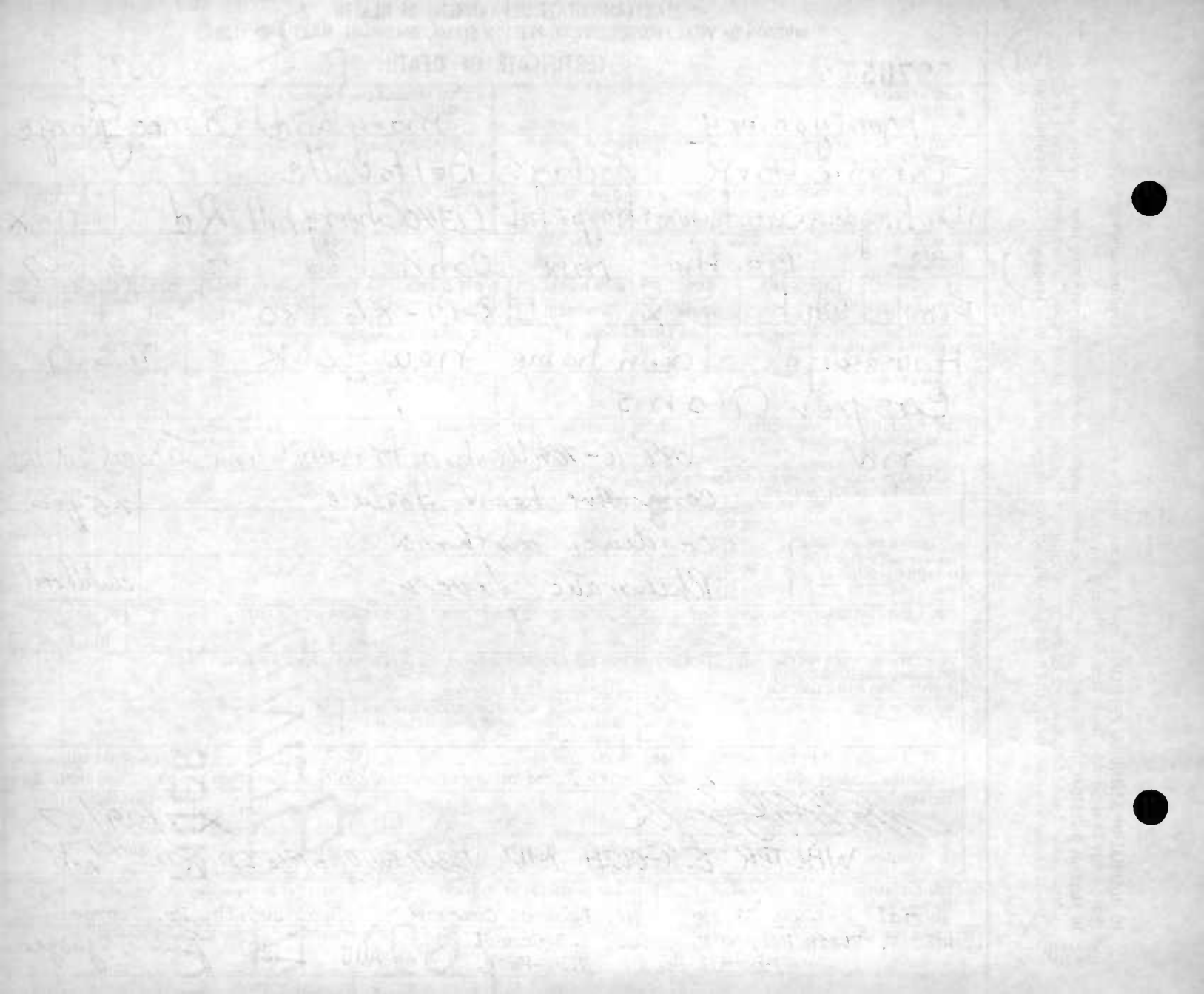
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09705

09710

| | | | |
|---|-------------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Beltsville</u> | |
| c. LENGTH OF STAY IN 1b <u>5 days</u> | | d. STREET ADDRESS <u>11340 Cherryhill Rd</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Bertha</u> First <u>None</u> Middle <u>Cohn</u> Last | | 4. DATE OF DEATH Month <u>7</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8-17-86</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>2</u> Days <u>29</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Casper Gron s</u> | | 14. MOTHER'S MAIDEN NAME <u>?</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>088-16-7698</u> | |
| 17. INFORMANT <u>Washington Sanitarium</u> Address <u>Takoma Park, Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4342 Congestive heart failure</u>
DUE TO (b) <u>cardiac asthma</u>
DUE TO (c) <u>Rheumatic fever</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u>
<u>childhood</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-21</u> , 19 <u>67</u> , to <u>7-29</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7-29</u> , 19 <u>67</u> , and that death occurred at <u>8:15 P.M.</u> from causes on and on the date stated above. | | | |
| 22a. SIGNATURE <u>Walter E. Goozh</u> | | 22b. DATE SIGNED <u>7/29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>WALTER E. GOOZH MD</u> | | 22d. ADDRESS <u>2309 SHOREFIELD RD WHEATON MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 31, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Hyattsville, Pr. George, MD.</u> | |
| 24. FUNERAL DIRECTOR <u>Donald M. Stein Hebrew Memorial</u> ADDRESS <u>252 Carroll St.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 1967</u> | |
| Funeral Home <u>N.W.-Wash., D.C.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | |



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09706

09711

| | | | |
|--|-------------------------------|---|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>
c. LENGTH OF STAY IN 1b <u>D.O.A.</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>FLORIDA</u> b. COUNTY <u>SEMINOLE</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>APOPKA</u>
d. STREET ADDRESS <u>3051 CECELIA DRIVE</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>FRANK EDWARD COLE</u> | | 4. DATE OF DEATH Month Day Year
<u>JULY 19 19 67</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>2-8-63</u> |
| 9. AGE (In years lost birthday) <u>4</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CHILD</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>FLORIDA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>GORDON WILLIAM COLE</u> | | 14. MOTHER'S MAIDEN NAME <u>ETHYLE ROBBINS</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>GORDON W. COLE</u> | | Address <u>(SAME AS ABOVE)</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiorespiratory Failure</u>
DUE TO (b) <u>due to Asphyxiation due to</u>
DUE TO (c) <u>Drowning</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II (Item 18).)
<u>Deceased fell in pool in back yard and drowned.</u> | |
| 20c. TIME OF INJURY Month, Day, Year
<u>7:30 p.m. 7-19 1967</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | | 20f. (City or town) <u>Apopka</u> (County) <u>Howard</u> (State) <u>Fla</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>7-20-1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | Address (Street, City, town, or county) <u>Wheaton, Md.</u> | |
| 23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 24, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u> | | 23d. LOCATION (City or town) (County) (State) <u>Wheaton Park, Florida</u> | |
| 24. FUNERAL DIRECTOR <u>James Staller</u> | | 25a. REC'D BY REGISTRAR <u>JUL 24 1967</u> | |
| ADDRESS <u>254 Carroll St NW</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

02710

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

09707

CERTIFICATE OF DEATH

09712

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b
3 weeks | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
3709 Elby Street | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | |
| f. STREET ADDRESS
Route 1, Stony Creek Rd. | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
HELEN LEE CONNELLY | | 4. DATE OF DEATH
Month July Day 18 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 7, 1898 |
| 9. AGE (In years birthday)
68 yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Ollie Downes | | 14. MOTHER'S MAIDEN NAME
Julia Duley | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-24-3397 | |
| 17. INFORMANT
Daughter | | Address P.O. Box 405 Mrs. Louise L. Richard- Glendale, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pul. embolism
DUE TO (b) Carcinoma of the breast
DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
3 mos
2 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Diabetes Mellitus & U.S.D. (ASCD) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/2/19 54 to 7/18/19 67 that (I) (we) last saw the deceased alive on 7/17/19 67 , and that death occurred at 3:30 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stephen N. Jones | | 22b. DATE SIGNED
7/18/67 | |
| 22c. PHYSICIAN'S NAME (Type)
STEPHEN N. JONES | | 22d. ADDRESS
809 Veirs Mill Rd. Rockville, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-21-67 | 23c. NAME OF CEMETERY OR CREMATORY
Darnestown Cemetery | 23d. LOCATION (City or Town) (County) (State)
Darnestown, Maryland |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
JUL 24 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02701

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09713

| | | | |
|---|------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN lb
<u>3 hr. 10 min</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Suburban Hospital</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>R) Bethesda</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Donald L Cooper</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>21</u> Year <u>1967</u> | |
| 5. SEX
<u>M.</u> | 6. COLOR OR RACE
<u>Negroid</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 9, 1943</u> |
| 9. AGE (In years lost birthday)
<u>24</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Auto Mechanic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Auto Mechanic</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S. A.</u> | |
| 13. FATHER'S NAME
<u>Ernest Cooper</u> | | 14. MOTHER'S MAIDEN NAME
<u>Dorothy Thomas</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>982X</u> IMMEDIATE CAUSE (a) <u>Penetrating wound rt atrium with hemopericardium</u>
DUE TO <u>and hemothorax, bilaterally</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>knife wounds</u>
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Struck in chest in fight</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>3:15 PM</u> <u>7/21</u> 19 <u>67</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Side walk</u> | | 20f. (City or town) (County) (State)
<u>Rockville Montgomery Md</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<u>John S. Ball</u> | | 22. DATE SIGNED
<u>7/22/67</u> | |
| EXAMINER'S NAME (Type)
<u>John S. Ball</u> | | M.D.
CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/26/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Park</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville Montg. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Robert L. Snowden</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| ADDRESS
<u>Rockville, Md</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |
| DATE
<u>JUL 27 1967</u> | | | |

09709

CERTIFICATE OF DEATH

09714

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN 1b
35 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
The Clinical Center, Bethesda, Md. 20014 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
4319 River Road N. W., Apt. 1
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Stephen Nicholas Cooper | | 4. DATE OF DEATH
Month Day Year
July 21 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
September 27, 1921
9. AGE (In years last birthday)
45 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Assistant Supervisor | | 10b. KIND OF BUSINESS OR INDUSTRY
Federal Government | |
| 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Cooper | | 14. MOTHER'S MAIDEN NAME
Anna Mulich | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes 1942-1945 | | 16. SOCIAL SECURITY NO.
Not available | |
| 17. INFORMANT
The Medical Record | | Address
The Clinical Center, Bethesda, Md. 20014 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Probable septicemia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Candidiasis - gastrointestinal tract
DUE TO
(c) Acute Myelogenous Leukemia | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 16, 1967 , to July 21, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 21, 1967 , and that death occurred at 4:45 M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Thomas Clancy | | 22b. DATE SIGNED
22 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Thomas Clancy, M.D. | | 22d. ADDRESS
The Clinical Center, National Institutes of Health, Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
July 24, 67 | 23c. NAME OF CEMETERY OR CREMATORY
St. Mary Magdalene Cem., Easton, Pennsylvania | 23d. LOCATION (City or Town) (County) (State) |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY | | 25a. REC'D BY REGISTRAR
BETHESDA, MD. | |
| 25b. REC'D BY REGISTRAR
JUL 25 1967 | | 25c. REGISTRAR'S SIGNATURE
[Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

REPORT OF THE

1910

OF THE

COMMISSIONERS OF THE

LAND

AND

WATER

RESOURCES

OF THE

UNITED STATES

DEPARTMENT OF AGRICULTURE

WASHINGTON

1910

1910

1910

1910

1910

1910

1910

1910

1910

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>Minutes</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San & Hospital</u> | | d. STREET ADDRESS <u>10608 Sweetbrier Pkwy</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Charlotte Marie Copping</u> | | 4. DATE OF DEATH <u>7 10 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 7-12 55</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Manila, Philippines</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u> | |
| 13. FATHER'S NAME <u>Albert Brazee</u> | | 14. MOTHER'S MAIDEN NAME <u>Consuelo Palma</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Hus. Bennett Copping</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u> | | | |
| (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Read</u> M.D. | | 22. DATE SIGNED <u>July 10, 1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 13, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>8434 Georgia Avenue</u> | | 25a. REC'D BY REGISTRAR <u>JUL 14 1967</u> | |
| Warner E. Pumphrey, Inc. Silver Spring, Md. | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

10428

2.

66

09711

CERTIFICATE OF DEATH

09716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Bronx NY. <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince Georges</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Capital Heights W. HYATTSVILLE</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>University Nursing Home</u> | | d. STREET ADDRESS
<u>@ 2807 Nicholson St. Hyattsville</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Frank James Corbett</u> | | 4. DATE OF DEATH <u>July 23 1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4/29/1887</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Transit operator</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Bronx NY.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>JAMES J. CORBETT</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY O'NEIL</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>YES W.W.I.</u> | | 16. SOCIAL SECURITY NO. <u>578 10 6665A</u> | |
| 17. INFORMANT <u>IVAH V CORBETT.</u> | | Address <u>SAME AS #2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Arrhythmia</u>
DUE TO (b) <u>Myocardial Infarction</u>
DUE TO (c) <u>Other: Sclerotic Heart Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 months</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Chronic Pyelo Nephritis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/21/67</u> to <u>7/23/67</u> , that (I) (we) last saw the deceased alive on <u>7/22/67</u> , and that death occurred at <u>9:30 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>E. Stuart Lydanne</u> | | 22b. DATE SIGNED <u>7/23/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>E. STUART LYDANNE</u> | | 22d. ADDRESS <u>3066 QUE ST. N.W. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>JULY 27, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>FORT LINCOLN CEM.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>BLADENSBURG, MARYLAND</u> | |
| 24. FUNERAL DIRECTOR <u>W. W. Chambers Co Riverdale Md</u> | | 25a. REC'D BY REGISTRAR <u>JUL 27 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u> | |

CONTINUED OF DEATH

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

of poverty

JUL 27 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G391 7/27/67

CERTIFICATE OF DEATH

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN lb
15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1643 E. Jefferson Street | | d. STREET ADDRESS
1643 E. Jefferson Street | |
| 3. NAME OF DECEASED
(Type or print) EDWIN T. CORNELIUS | | 4. DATE OF DEATH July 20, 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/24/87 |
| 9. AGE (In years last birthday)
80 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Missouri | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Samuel Cornelius | | 14. MOTHER'S MAIDEN NAME
Delilah Lear | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
449-50-6236 | |
| 17. INFORMANT
Lottie R. Cornelius-Item# 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
2041 IMMEDIATE CAUSE (a) GRANULOCYTIC LEUKEMIA
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | INTERVAL BETWEEN ONSET AND DEATH
2 1/2 years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from JUNE, 1963 , to 7-20, 1967 , that (I) (we) last saw the deceased alive on 7-20, 1967 , and that death occurred at 2:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. G. Hall | | 22b. DATE SIGNED
7-20-67 | |
| 22c. PHYSICIAN'S NAME (Type) W. G. Hall | | 22d. ADDRESS
615 W. Montg. Ave., Rockville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/24/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parklawn | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md. | | 25a. REC'D BY REGISTRAR
JUL 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

09713

CERTIFICATE OF DEATH

09718

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LAXONA PARK</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> | |
| c. LENGTH OF STAY IN 1b <u>1 hour</u> | | d. STREET ADDRESS <u>7705 24th Avenue</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASHINGTON SAN. & HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Harry</u> First <u>Gibbons</u> Middle <u>Crabtree</u> Last | | 4. DATE OF DEATH <u>July 21</u> Month <u>21</u> Day <u>1967</u> Year | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>December 18, 1913</u> |
| 9. AGE (In years last birthday) <u>53</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Peoples Drug Store Tenn.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Tenn.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Isaac Walker Crabtree</u> | | 14. MOTHER'S MAIDEN NAME <u>Emmalynne Murphree</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>415-12-2304</u> | |
| 17. INFORMANT <u>Sara Crabtree</u> Address <u>7705 24th Avenue Adelphi, Maryland</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>
DUE TO (b) <u>Congestive heart failure</u>
DUE TO (c) <u>Arteriosclerotic heart disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 hour</u>
<u>1 hour</u>
<u>10 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Hypertension</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 1957, to <u>July 21</u> , 1967, that (I) (we) last saw the deceased alive on <u>June 17</u> , 1967, and that death occurred at <u>5:05</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Seruch T. Kimble</u> | | 22b. DATE SIGNED <u>7-21-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Seruch T. Kimble</u> | | 22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 25, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

UNITED STATES OF AMERICA

1971

1971

1971

1971

1971

1971

1971

1971

4 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|---|---|--|
| 09714 | | 09719 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY IN lb <u>15 hrs</u> | | d. STREET ADDRESS <u>1703 East-West Highway</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Louise C Cressler</u> | | 4. DATE OF DEATH <u>July 14 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-25-1877</u> |
| 9. AGE (In years last birthday) <u>89 yrs.</u> | | 10. IF UNDER 1 YEAR: Months <u>14</u> Days <u>19</u> Hours <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Nebraska</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Matthew Inbelder</u> | | 14. MOTHER'S MAIDEN NAME <u>Wilhelmina Eickoff</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO. <u>213-50-4911</u> | |
| 17. INFORMANT <u>Mrs. Donald Staley</u> Address <u>1703 East-West Hwy. Hospital Chart, Washington Sanitarium</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>B. candida pneumonia</u>
DUE TO (b) <u>Silver Spring</u>
DUE TO (c) <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Uremia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April 1963</u> , to <u>7-14, 1967</u> ; that (I) (we) last saw the deceased alive on <u>7-14 1967</u> , and that death occurred at <u>11:12 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Senuch T. Kimble</u> | | 22b. DATE SIGNED <u>7-16-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Senuch T. Kimble</u> | | 22d. ADDRESS <u>927 Pershing Dr., Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 18, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u> |
| 24. FUNERAL DIRECTOR <u>John B. Thomas</u> ADDRESS <u>434 Georgia Avenue</u> | | 25a. REC'D BY REGISTRAR <u>JUL 19 1967</u> | |
| <u>Warner C. Humphrey, Inc. Silver Spring, Md.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

UNITED STATES OF AMERICA

1

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

UNITED STATES OF AMERICA

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 shall be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09715

09720

| | | | | | |
|---|----------------------------------|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Mont.</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u> | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Beaflorida</u> | | c. LENGTH OF STAY IN 1b
<u>7 hrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Suburban</u> | | | d. STREET ADDRESS
<u>305 N. Adams St. Apt 4</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First <u>Baby</u> Middle <u>Boy</u> Last <u>Crider</u> | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>23</u> Year <u>1967</u> | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7/23/67</u> | 9. AGE (In years last birthday)
yrs. <u>7</u> | IF UNDER 1 YEAR
Months <u>7</u> Days <u>1</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | |
| 13. FATHER'S NAME
<u>Fred Crider</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S. A.</u> | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, unknown) <u>no</u> | | | 16. SOCIAL SECURITY NO.
<u>no</u> | | |
| 17. INFORMANT
<u>mother's chart.</u> | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Neonatal atelectasis</u>
<u>7625</u> DUE TO (b) <u>Prematurity</u>
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>12 hrs.</u>
<u>12 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | 20g. (County) | | 20h. (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1967</u> , to <u>July 23, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 23, 1967</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Edward J. Fivoli</u> | | | 22b. DATE SIGNED
<u>7/23/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type) | | | 22d. ADDRESS | | |
| 23a. BURIAL <input type="checkbox"/> CREMATION <input checked="" type="checkbox"/> REMOVAL (Specify) | | 23b. DATE THEREOF
<u>7/24/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Suburban Hospital</u> | |
| 23d. LOCATION (City, town or county) | | 23e. (State) | | 23f. (Country) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Mrs. Amelia C. Carter - Administrator</u> | | | 25a. REC'D BY REGISTRAR
<u>JUL 28 1967</u> | | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | 25c. ADDRESS | | |

VR A15 (4)
15M 9/60

7-193294

(10)

(1)

(1)

[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

[Faint handwritten text at the bottom of the page, including what appears to be a date "JUL 28 1967" and a signature or name.]

09716

CERTIFICATE OF DEATH

09721

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton
c. LENGTH OF STAY IN 1b
3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
University Nursing Home | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
District of Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington
d. STREET ADDRESS
844 Jefferson St., N.W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
Thomas Walter Crockett | | 4. DATE OF DEATH
Month 7 Day 27 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
March 3, 1899 |
| 9. AGE (In years last birthday)
68 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 27 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Handyman | | 10b. KIND OF BUSINESS OR INDUSTRY
South Carolina | |
| 11. BIRTHPLACE (County & State, or foreign country)
USA | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John Crockett | | 14. MOTHER'S MAIDEN NAME
Louise Galmon | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
578-05-6276 | |
| 17. INFORMANT
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
153.7
IMMEDIATE CAUSE (a) Adeno carcinoma of cecum
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) and Transverse Colon
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from July 25, 1967 , to July 27, 1967 , that (I) (we) last saw the deceased alive on July 25, 1967 , and that death occurred at 7:30 A.M. , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Blanche G. Bendler | | 22b. DATE SIGNED
7-28-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Blanche G. Bendler | | 22d. ADDRESS
10820 Georgia Avenue Wheaton, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
8-1-67 | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Memorial Park | 23d. LOCATION (City or Town) (County) (State)
Landover, P. G., Md. |
| 24. BURIAL DIRECTOR
Hall Bros. Funeral Home, 621 Fla., Ave., N.W. Washington, D. C. | | 25a. REC'D BY REGISTRAR
AUG 2 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

UNIVERSITY OF CHICAGO

Office of the Registrar

and

Registrar

Registrar

Box 377, Chicago, Ill.

Box 377, Chicago, Ill.

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

1957

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09722

| | | | | | | | | | | |
|---|--|--|---|---|--|--|--------------------------------------|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jakoma Park | | c. LENGTH OF STAY IN 1b
3 years | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Montgomery | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
616 Elm Street | | | | e. STREET ADDRESS
616-Elm Street | | | | f. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Mary E Curtis | | | 4. DATE OF DEATH
Month Day Year
July 4 19 67 | | | 5. SEX
Female | | 6. COLOR OR RACE
White | | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 18, 1894 | | 9. AGE (In years last birthday) yrs.
73 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | | 11. IF UNDER 24 HRS.
Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | | | 11. BIRTHPLACE (County & State, or foreign country)
Germantown, Maryland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Charles Wallace Hughes | | | | | 14. MOTHER'S MAIDEN NAME
Martha Biggs | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | 16. SOCIAL SECURITY NO
577-05-8979 | | | 17. INFORMANT
Harry J. Curtis | | | 18. ADDRESS
616 Elm Street, Jakoma Park, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ventricular fibrillation (acute)
DUE TO (b) Arteriosclerotic cardiovascular disease
DUE TO (c) 10 yrs. | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (his hospital) attended the deceased from July 3, 1967 , to July 4, 1967 that (I) (we) last saw the deceased alive on July 3, 1967 , and that death occurred at 9 P.M. , from causes and on the date stated above. | | | | | | | | | | |
| 22a. SIGNATURE
John D. Guiswold | | | | | | 22b. DATE SIGNED
4 July 1967 | | 22c. PHYSICIAN'S NAME (Type)
John D. Guiswold M.D. | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 7, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Darnestown Presbyterian Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Darnestown, Maryland | | | | |
| 24. FUNERAL DIRECTOR
C. Glen Carter | | | | | | 25a. REC'D BY REGISTRAR
JUL 7 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|----------------------|--|
| 1. Name of the person or organization
2. Address
3. City
4. State
5. Zip | | 6. Date
7. Time | |
| 8. Subject
9. Description of the event or activity | | 10. Remarks | |
| 11. Name of the person or organization
12. Address
13. City
14. State
15. Zip | | 16. Date
17. Time | |
| 18. Subject
19. Description of the event or activity | | 20. Remarks | |
| 21. Name of the person or organization
22. Address
23. City
24. State
25. Zip | | 26. Date
27. Time | |
| 28. Subject
29. Description of the event or activity | | 30. Remarks | |
| 31. Name of the person or organization
32. Address
33. City
34. State
35. Zip | | 36. Date
37. Time | |
| 38. Subject
39. Description of the event or activity | | 40. Remarks | |
| 41. Name of the person or organization
42. Address
43. City
44. State
45. Zip | | 46. Date
47. Time | |
| 48. Subject
49. Description of the event or activity | | 50. Remarks | |
| 51. Name of the person or organization
52. Address
53. City
54. State
55. Zip | | 56. Date
57. Time | |
| 58. Subject
59. Description of the event or activity | | 60. Remarks | |
| 61. Name of the person or organization
62. Address
63. City
64. State
65. Zip | | 66. Date
67. Time | |
| 68. Subject
69. Description of the event or activity | | 70. Remarks | |
| 71. Name of the person or organization
72. Address
73. City
74. State
75. Zip | | 76. Date
77. Time | |
| 78. Subject
79. Description of the event or activity | | 80. Remarks | |
| 81. Name of the person or organization
82. Address
83. City
84. State
85. Zip | | 86. Date
87. Time | |
| 88. Subject
89. Description of the event or activity | | 90. Remarks | |
| 91. Name of the person or organization
92. Address
93. City
94. State
95. Zip | | 96. Date
97. Time | |
| 98. Subject
99. Description of the event or activity | | 100. Remarks | |

CERTIFICATE OF DEATH

09718

09728

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

IV

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D. C.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | |
| c. LENGTH OF STAY IN 1b
<u>1 mo.</u> | | d. STREET ADDRESS
<u>1301 Kalmia Road N. W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Ella m. Dasser</u> | | 4. DATE OF DEATH
Month Day Year
<u>7 3 19 67</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/16/81</u> |
| 9. AGE (In years last birthday)
<u>85</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>H W</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>-</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Massachusetts</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>Patrick Leary</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ellen Calnan</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>-</u> | |
| 17. INFORMANT
<u>Mrs. Nell Leary</u> | | Address
<u>4550 Conn. Ave. N.W. Wash DC</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>331X</u>
DUE TO <u>Cerebral Hemiplegia</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u>
DUE TO (c) <u>5 days</u>
<u>1 year</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO (a) TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/20/67</u> to <u>7/3/67</u> , that (I) (we) last saw the deceased alive on <u>7/2/67</u> , and that death occurred at <u>5:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John J. Curry</u> | | 22b. DATE SIGNED
<u>7/3/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John J. Curry</u> | | 22d. ADDRESS
<u>18620 Georgia Avenue</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>6-6-67</u> | 23c. NAME OF CEMETERY OR CREMATORIUM
<u>Mt. Olivet</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D. C.</u> |
| 24. FUNERAL DIRECTOR
<u>Francis J. Collins</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 6 1967</u> | |
| ADDRESS
<u>F. J. COLLINS 3821-14th ST. N.W. WASH. D.C.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

REPORT OF DATA

D. C.

Washington

1501 Columbia Road, N. W.

Miss Gorman

Patricia Lantry

no

Washington, D. C. 20004

Ms. 10152

Washington, D. C.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09719

CERTIFICATE OF DEATH

09724

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|--|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | c. LENGTH OF STAY IN lb
<u>3 Weeks</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>University Nursing Home Wheaton, Md.</u> | | | d. STREET ADDRESS
<u>11225 Newport Mill Rd.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Margaret Nolia Davis</u> | | | 4. DATE OF DEATH
Month Day Year
<u>July 19, 1967</u> | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Caus.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/12/1903</u> | 9. AGE (In years last birthday) yrs.
<u>64</u> | IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Hazleton, Pennsylvania</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | 13. FATHER'S NAME
<u>James Jones</u> | | |
| 14. MOTHER'S MAIDEN NAME
<u>(Unknown) Edwards</u> | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | |
| 16. SOCIAL SECURITY NO.
<u>553-52-7115</u> | | | 17. INFORMANT
<u>Son George A. Davis -Kensington, Md.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CEREBROVASCULAR DISEASE</u>
DUE TO
(c) | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>7 days</u>
<u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> , 19 <u>67</u> , to <u>7/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/19</u> , 19 <u>67</u> , and that death occurred at <u>1 A</u> M, from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
<u>Richard H. Pollen</u> | | | 22b. DATE SIGNED
<u>7/19/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>RICHARD H. POLLEN</u> | | | 22d. ADDRESS
<u>10400 CONNECTICUT AVE, KENSINGTON, MD</u> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>7-22-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Monocacy Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Beallsville, Maryland</u> | | |
| 24. FUNERAL DIRECTOR
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 24 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

STATEMENTS OF DEBTS

Page 1

Debtor's Name

Address

City

Occupation

Income

Assets

Liabilities

Signature

Date

Witness

Notary Public

Notary Seal

Notary Commission Expires

Notary Signature

Notary Title

Notary Seal

Notary Commission Expires

Notary Signature

Notary Title

Notary Seal

Notary Commission Expires

Notary Signature

Notary Title

Notary Seal

Notary Commission Expires

Notary Signature

Notary Title

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department at Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09720

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09725

| | | | | | | | |
|---|--|---|--|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | c. LENGTH OF STAY IN lb
6 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | | | d. STREET ADDRESS
1111 University Blvd., W., #806 | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) WILLIAM J. DAVIS | | | | 4. DATE OF DEATH
Month July Day 24 Year 1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/25/1900 | |
| 9. AGE (In years last birthday) yrs. 66 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Self-employed Broker | | 11. BIRTHPLACE (State or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
Thomas William Davis | | | | 14. MOTHER'S MAIDEN NAME
Melissa Womack | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | 16. SOCIAL SECURITY NO.
579-05-9987 | | 17. INFORMANT
Mabel B. Davis | | Address 1111 University Blvd. W Silver Spring, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary insufficiency
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Arteriosclerotic heart disease
DUE TO
(c) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. _____ p.m. 19 | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Belden R. Reap M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED 7/24/1967 | |
| EXAMINER'S NAME (Type) BELDEN R. REAP MD. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, City, County or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF July 27, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery | | 23d. LOCATION (City or town) (County) (State) Prince Georges Co., Md. | |
| 24. FUNERAL DIRECTOR John B. Thomas John B. Thomas 434 Georgia Avenue | | | | 25a. REC'D BY REGISTRAR JUL 31 1967 | | 25b. REGISTRAR'S SIGNATURE John B. Thomas | |
| 26. FUNERAL HOME Warner E. Humphrey, Inc. Silver Spring, Maryland | | | | | | | |

University

University

University

Silver Spring

6 days

Silver Spring

1111 University Blvd., W., 4000

Holy Cross Hospital

July 24 1967

1.

WILLIAM

8/25/1900

1

White

Male

North Carolina

Self-employed

U.S.

1111 University Blvd., W., 4000

7-10-67 (Rev. 1-1-67)

11

11

CERTIFICATE OF DEATH

09726

09721

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i> | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | c. LENGTH OF STAY IN lb
<i>30 years</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<i>Maryland</i> | | b. COUNTY
<i>Montgomery</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | d. STREET ADDRESS
<i>1314 Cresthaven Drive</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<i>GRACE Elizabeth</i> | | 4. DATE OF DEATH
Month <i>July</i> Day <i>26</i> Year <i>19 67</i> | | 5. SEX
<i>female</i> | | 6. COLOR OR RACE
<i>white</i> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>July 15, 1899</i> | | 9. AGE (In years lost birthday) yrs.
<i>68</i> | | 10. IF UNDER 1 YEAR
Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Housewife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Own home</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Hampton, Virginia</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>John M. Walker</i> | | 14. MOTHER'S MAIDEN NAME
<i>Susan Jane Bulifant</i> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>214-05-2561</i> | |
| 15. INFORMANT
<i>Herman M. Dilg</i> | | 16. ADDRESS
<i>1314 Cresthaven Drive Silver Spring, Maryland</i> | | 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<i>1538</i> IMMEDIATE CAUSE (a) <i>Carcinoma of Colon</i>
DUE TO (b) <i>over one year</i>
DUE TO (c) <i>year</i> | | 18. INTERVAL BETWEEN ONSET AND DEATH
<i>over one year</i> | | PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <i>19</i> p.m. <i>19</i> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <i>May 29, 19 67</i> to <i>July 26, 19 67</i> , that (I) (we) last saw the deceased alive on <i>7/26 1967</i> , and that death occurred at <i>7:35 AM</i> , from causes and on the date stated above. | | 22a. SIGNATURE
<i>Norman H. Rubenstein</i> | | 22b. DATE SIGNED
<i>7/26/67</i> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>Norman H. Rubenstein, M.D.</i> | | 22d. ADDRESS
<i>11161 New Hampshire Ave. S. S. Md.</i> | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>July 29, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Fort Lincoln Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Prince Georges Co. Md.</i> | | 25a. REC'D BY REGISTRAR
<i>JUL 31 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Form with multiple sections and fields, including a header area with a title, a large central table with several columns, and a footer area with additional information. The text is faint and mostly illegible.

Vertical text on the right side of the page, possibly a date or reference number, oriented vertically.

09722

CERTIFICATE OF DEATH

09727

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|-------------------------------|--|---|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN 1b <u>68 Days</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE <u>New York</u> b. COUNTY <u>Queens</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jamaica</u> <u>69.3</u> | | | |
| 25d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>20014 The Clinical Center, Bethesda, Maryland</u> | | | | d. STREET ADDRESS <u>8824 166th Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Christopher</u> Last <u>Dillane</u> | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>30</u> Year <u>19 67</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>8 December 1935</u> | | 9. AGE (In years last birthday) <u>31</u> yrs. | IF UNDER 1 YEAR Months <u> </u> Days <u> </u> | IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Fireman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Fire Protection</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Ireland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Thomas Dillane</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Catherine McNamara</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes 1959 - 59</u> | | 16. SOCIAL SECURITY NO. <u>132-32-2424</u> | | 17. INFORMANT <u>The Medical Records, The Clinical Center, Bethesda, Maryland 20014</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Insufficiency</u>
<u>178x</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Trophoblastic Carcinoma Metastatic to Lungs</u> DUE TO
(c) <u>Primary site - left testis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 months</u>
<u>3 months</u>
<u>Unknown</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <u> </u> (this hospital) attended the deceased from <u>23 May</u> , 19 <u>67</u> , to <u>30 July</u> , 19 <u>67</u> , that <u> </u> (we) last saw the deceased alive on <u>30 July</u> , 19 <u>67</u> , and that death occurred at <u>12:25 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>William E. Bridson</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED <u>30 July 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>William E. Bridson, M.D.</u> | | | | 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7/31/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>QUEENS, NEW YORK CITY, NY</u> | | 23d. LOCATION (City or Town) (County) (State) | |
| 24. FUNERAL DIRECTOR <u>HYSONG'S FUNERAL HOME</u> | | ADDRESS <u>WASH.D.C. 1300 N.ST,N.W.</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

569545

0.358A

U.S. DEPARTMENT OF JUSTICE

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09728

| | | | | | | | |
|---|------------------------------|---|------------------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MD. b. COUNTY MONTGOMERY | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN lb
2 1/2 hrs | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS HOSPITAL | | | | d. STREET ADDRESS
4 PARKSIDE RD. | | | |
| 3. NAME OF DECEASED (Type or print)
First ARTHUR Middle ASA Last DILLON | | | | 4. DATE OF DEATH
Month 7 Day 31 Year 1967 | | | |
| 5. SEX
M | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2/19/01 | | 9. AGE (In years last birthday)
66 yrs. | 10. IF UNDER 1 YEAR
Months 6 Days 11 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Printer, U. S. Govt. | | 10b. KIND OF BUSINESS OR INDUSTRY
Printing | | 11. BIRTHPLACE (State or foreign country)
Mc Clouth, Kansas | | 12. CITIZEN OF WHAT COUNTRY?
U. S. A. | |
| 13. FATHER'S NAME
George F. Dillon | | | | 14. MOTHER'S MAIDEN NAME
Emma Jones | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-44-9337 | | 17. INFORMANT
Alethea B. Dillon Address 4 Parkside Road Silver Spring, Maryland | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Massive
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Pulmonary Embolus.
DUE TO
(b) Pulmonary Embolus.
(c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Ca of Prostate with Retroperitoneal Metastasis | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Read | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED
July 31, 1967 | |
| EXAMINER'S NAME (Type)
BELDEN R. READ, MD. | | Address (Street, City, town, or county)
Silver Spring, Maryland | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
August 4, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Colesville Methodist Cem. | | 23d. LOCATION (City or town) (County) (State)
Colesville, Maryland | |
| 24. FUNERAL DIRECTOR
C. Glen Carter | | Address
8434 Georgia Avenue | | 25a. REC'D BY REGISTRAR
AUG 3 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| Funeral Home
Warner E. Humphrey, Inc. | | Address
Silver Spring, Maryland | | | | | |

CERTIFICATE OF DEATH

09724

09729

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Holy Cross Hospital | | d. STREET ADDRESS
3608 Randolph Rd | |
| 3. NAME OF DECEASED
(Type or print) Benjamin-Franklin- Dixon | | 4. DATE OF DEATH
Month 7 Day 22 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-17-05 |
| 9. AGE (In years lost birthday)
62 yrs. | | 10. IF UNDER 1 YEAR
Months 7 Days 22 Hours 15 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
carpenter | | 11b. KIND OF BUSINESS OR INDUSTRY | |
| 12. BIRTHPLACE (County & State, or foreign country)
Davidsonville, Md | | 13. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 14. FATHER'S NAME
Eldridge Edwin Dixon | | 15. MOTHER'S MAIDEN NAME
Frances Phipps | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no (If yes give war or dates of service) | | 17. SOCIAL SECURITY NO.
577-22-0730 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION
DUE TO
(b) CORONARY THROMBOSIS
DUE TO
(c) ATHEROSCLEROSIS | | 19. INTERVAL BETWEEN ONSET AND DEATH
2 Hours +
HOURS + ?
YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 15 , 19 67 , to July 22 , 19 67 , that (I) (we) lost saw the deceased alive on July 15 , 19 67 , and that death occurred at 11:45 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Hugo G. Graziani, M.D.
Dr. John C. Cury, M.D. | | 22b. DATE SIGNED
7/22/67 | |
| 22c. PHYSICIAN'S NAME (Type)
HUGO G. GRAZIANI, M.D. | | 22d. ADDRESS
10101 GEORGIA AVE., S.S., MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
July 26 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Rockville Mount | | 23d. LOCATION (City or town) (County) (State)
Rockville Mount Md | |
| 24. FUNERAL DIRECTOR
John C. Cury | | 25a. REC'D BY REGISTRAR
JUL 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE
John C. Cury | | 25c. REGISTRAR'S NAME
John C. Cury | |

THE NATIONAL ARCHIVES COLLEGE PARK, MARYLAND

RECORDS OF THE

1914-1915

1916-1917

1918-1919

1920-1921

1922-1923

1924-1925

1926-1927

1928-1929

1930-1931

1932-1933

1934-1935

1936-1937

1938-1939

1940-1941

1942-1943

1944-1945

1946-1947

1948-1949

1950-1951

1952-1953

1954-1955

1956-1957

1958-1959

1960-1961

1962-1963

1964-1965

1966-1967

1968-1969

1970-1971

1972-1973

1974-1975

00725

CERTIFICATE OF DEATH

09730

| | | | | | | | | | | | |
|---|---|--|--|------------------|--|--------|------|-------|------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring
d. STREET ADDRESS 3709 Elby Street
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) Burgess E Dodson | | 4. DATE OF DEATH
Month July Day 15 Year 19 67 | | | | | | | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
10-3-1904 | | | | | | | | |
| 9. AGE (In years last birthday) 62 yrs. <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table> | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | Months | Days | Hours | Min. | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | | | | | | | |
| Months | Days | Hours | Min. | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Body & Fender | | 10b. KIND OF BUSINESS OR INDUSTRY
Auto | | | | | | | | | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME
Luther Dodson | | 14. MOTHER'S MAIDEN NAME
Ida | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no (If yes give war or dates of service) none | | 16. SOCIAL SECURITY NO.
579-07-9886 | | | | | | | | | |
| 17. INFORMANT Son | | 2006 Rockland Ave. Upton L. Dodson - Rockville, Md. | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) ARTERIOSCLEROTIC HEART DISEASE
DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH
1 day
years | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)
2 | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/14</u>, 19<u>67</u>, to <u>7/15</u>, 19<u>67</u>, that (I) (we) last saw the deceased alive on <u>7/15</u>, 19<u>67</u>, and that death occurred at <u>5 P</u> M, from causes and on the date stated above | | | | | | | | | | | |
| 22a. SIGNATURE
Richard H. Pollen | | 22b. DATE SIGNED
7/16/67 | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
RICHARD H. POLLEN MD | | 22d. ADDRESS
10400 CONNECTICUT AVE, KENSINGTON MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-18-67 | 23c. NAME OF CEMETERY OR CREMATORY
Monocacy Cemetery | 23d. LOCATION (City or Town) (County) (State)
Beallsville, Maryland | | | | | | | | |
| 24. FUNERAL DIRECTOR
Robert A. Rumphrey | | 25a. REC'D BY REGISTRAR
JUL 19 1967 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | 25c. REGISTRAR'S NAME
Charles Judge | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0 - cleared to SW Leap \rightarrow 5:50 p.m.!

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09726

CERTIFICATE OF DEATH

09731

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓
a. STATE <u>Pennsylvania</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. LENGTH OF STAY IN It
<u>17 Days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Easton</u> | | d. STREET ADDRESS
<u>505-B Charles Street</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Joseph</u> Middle <u>August</u> Last <u>Dold</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>20</u> Year <u>19 67</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>16 March 1920</u> |
| 9. AGE (In years lost birthday)
<u>47</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laboratory Technician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>John Dold</u> | | 14. MOTHER'S MAIDEN NAME
<u>Emily Miller</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes</u> <u>1942-1945</u> | | 16. SOCIAL SECURITY NO.
<u>203-09-1999</u> | |
| 17. INFORMANT
<u>The Medical Records</u>
<u>The Clinical Center, Bethesda, Maryland</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Status Epilepticus</u>
DUE TO
(c) <u>Craniopharyngioma</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) | | INTERVAL BETWEEN ONSET AND DEATH
<u>36 hours</u>
<u>38 hours</u>
<u>5 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 3</u> , 19 <u>67</u> , to <u>July 20</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 20</u> , 19 <u>67</u> , and that death occurred at <u>8:35</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert A. Ratcheson</u> M.D. | | 22b. DATE SIGNED
<u>20 July 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Robert A. Ratcheson, M.D.</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL REMOVAL</u> | | 23b. DATE THEREOF
<u>22 JULY 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>EASTON PA.</u> | | 23d. LOCATION (City or town) (County) (State) | |
| 24. FUNERAL DIRECTOR
<u>RINALDI FUNERAL HOME INC 7400 GEORGIA AVE. N.W.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 24 1967</u> | |
| ADDRESS <u>cc 20012</u> | | 25b. REGISTRAR'S SIGNATURE
<u>you Charles Yung</u> | |

09727

CERTIFICATE OF DEATH

09732

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton | | c. LENGTH OF STAY IN 1b
YRS | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton | | d. STREET ADDRESS
2608 Weisman Road | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
2608 Weisman Road | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First FRANCIS Middle J. Last DUNN | | 4. DATE OF DEATH
Month July Day 29 , Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Jan. 26, 1902 |
| 9. AGE (In years last birthday)
65 yrs. | | IF UNDER 1 YEAR
Months 65 Days 65 | IF UNDER 24 HRS.
Hours 65 Min. 65 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Sales Manager -Wheaton Dorr Co. | | 10b. KIND OF BUSINESS OR INDUSTRY
Penna. | 12. CITIZEN OF WHAT COUNTRY?
U. S. |
| 13. FATHER'S NAME
Peter Dunn | | 14. MOTHER'S MAIDEN NAME
Frances McDermott | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
171-01-9081A | |
| 17. INFORMANT
Wife | | Address
Same as Item 2. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Infection
DUE TO 163X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Metastatic Carcinoma
DUE TO Car. of Lung
(c) undx | | INTERVAL BETWEEN ONSET AND DEATH
120 d | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Aneurysm of aorta | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 3/1/67 , to 7/20/67 , that (I) (we) lost the deceased alive on 7/20/67 and that death occurred at 6:45 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Stephen N. Jones | | 22b. DATE SIGNED
7/31/67 | |
| 22c. PHYSICIAN'S NAME (Type)
STEPHEN N. JONES | | 22d. ADDRESS
809 Viers Mill Rd. Rockville, Md. | |
| 23a. BURIAL CREMATION, REMOVAL (Type)
Burial | 23b. DATE THEREOF
8-1-67 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven | 23d. LOCATION (City or town) (County) (State)
Silver Spring Mont. Md |
| 24. FUNERAL DIRECTOR
Robert A Pumphrey | | 25a. REC'D BY REGISTRAR
DATE AUG 3 1967 | |
| ADDRESS
7557 Wisconsin Ave Bethesda, Md | | 25b. REGISTRAR'S SIGNATURE
Charles J. Jones | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09728

CERTIFICATE OF DEATH

09733

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
District Of Columbia COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write Rural and give nearest town)
Bethesda | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
4361 Nichols Ave. S.E. WDC | |
| 3. NAME OF DECEASED (Type or print)
First Charles (NMN) Middle DWYER Last | | 4. DATE OF DEATH
Month 7 Day 31 Year 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 23. 1906 |
| 9. AGE (In years last birthday) yrs.
60 | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | 11. IF UNDER 24 HRS.
Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY
Military | |
| 11. BIRTHPLACE (County & State, or foreign country)
Crab Orchard, Illinois | | 12. CITIZEN OF WHAT COUNTRY?
U.S. | |
| 13. FATHER'S NAME
Edward L. DWYER | | 14. MOTHER'S MAIDEN NAME
Nora TRAVELSTEAD | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service)
Yes 1926 to 1957 | | 16. SOCIAL SECURITY NO.
299-50-47 | |
| 17. INFORMANT
Isabel M. Dwyer | | Address
4361 Nichols Ave S.W. WDC | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriolosclerotic Cerebral vascular disease
161X DUE TO severe with intracerebral vascular aneurysm
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 21 DUE TO Squamous cell carcinoma of larynx post operative
(c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 28 July, 1966 to 31 July, 1967 , that (I) (we) lost saw the deceased alive on 31 July 1967 , and that death occurred at 7:41 PM , from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
R. J. CAVANAGH | | 22b. DATE SIGNED
AUG. 1 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
R. J. CAVANAGH | | 22d. ADDRESS
Naval Hospital, Bethesda | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
8.4.1967 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington, National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Va. |
| 24. FUNERAL DIRECTOR
Lee Funeral | | 25a. REC'D BY REGISTRAR
Home 4th & Massachusetts, N.E. | 25b. REGISTRAR'S SIGNATURE
WDC
AUG 4 1967
Charles Judge |

EXHIBIT TO REPORT

District of Columbia

Department

Section

Case No.

Case No.

450 Lincoln Ave. S.E. D.C.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

Case No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

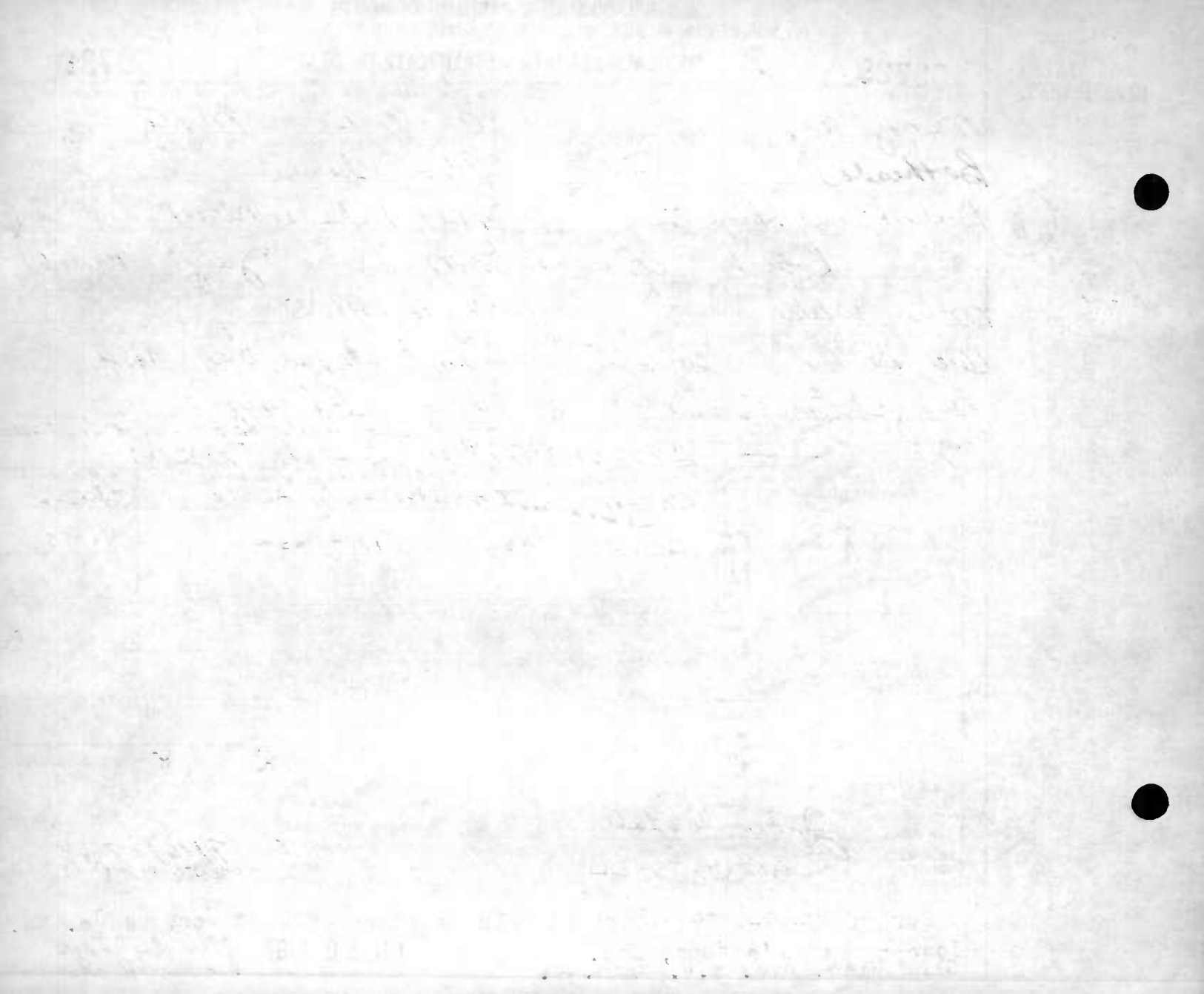
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN 1b <u>Do A</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u>
d. STREET ADDRESS <u>4809 Leland Street</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Robert Lawson Eastham</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>16</u> Year <u>1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Aug 12, 1908</u>
9. AGE <u>58</u> years (last birthday) yrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Oil Dealer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self-employed - Bethesda, Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George E. Eastham</u> | | 14. MOTHER'S MAIDEN NAME <u>Virginia E. Rigby</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> | | 16. SOCIAL SECURITY NO. <u>21732-5450</u> | |
| 17. INFORMANT <u>Mr. Robert Eastham, Jr. (Son)</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>
DUE TO (b) <u>Cordic Vascular Disease -</u>
stating the underlying cause last. (c) <u>4201</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | 22. DATE SIGNED <u>7/16/67</u> | |
| EXAMINER'S NAME (Type) <u>JOHN G. BALL</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) <u>MONTGOMERY CTY., MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7-19-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>
5130 Wisc. Ave. N.W. Wash. DC. | | 25a. REC'D BY REGISTRAR <u>JUL 20 1967</u>
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------|----------------------------------|---|--|---|--|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 09730 | | | | | | | | | | | |
| 09735 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN 1b <u>20 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 151
d. STREET ADDRESS <u>510 Azalea Drive</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Earl E. Edes</u>
First Middle Last | | | | | | 4. DATE OF DEATH
Month <u>7</u> Day <u>16</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/6/1892</u> | | 9. AGE (In years lost birthday) <u>75</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Schools</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Winn Co. Wis</u> | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | |
| 13. FATHER'S NAME <u>Augustus Edes</u>
XXXXXXXXXX | | | | | | 14. MOTHER'S MAIDEN NAME <u>Maria Cunningham</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>WWII</u> | | | | 16. SOCIAL SECURITY NO. <u>397-03-9012</u> | | 17. INFORMANT <u>Judith Edes</u> Address <u>Same as above</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u>
DUE TO <u>Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus & Hypertension</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
INTERVAL BETWEEN ONSET AND DEATH <u>10-15 yrs</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>April</u> , 1967, to <u>16 July</u> , 1967, that (I) (we) last saw the deceased alive on <u>16 July</u> , 1967, and that death occurred at <u>4:30</u> M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>W. Murphy</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>W. MURPHY</u> | | | | | | 22d. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | 23b. DATE THEREOF <u>7/19/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u> | | | |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> ADDRESS <u>Funeral Home-1331 Rockville Pike</u>
<u>Rockville, Maryland</u> | | | | | | 25a. REC'D BY REGISTRAR <u>JUL 18 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

Thompson

George

210

210

210

210

210

210

210

210

210

210

210

210

210

210

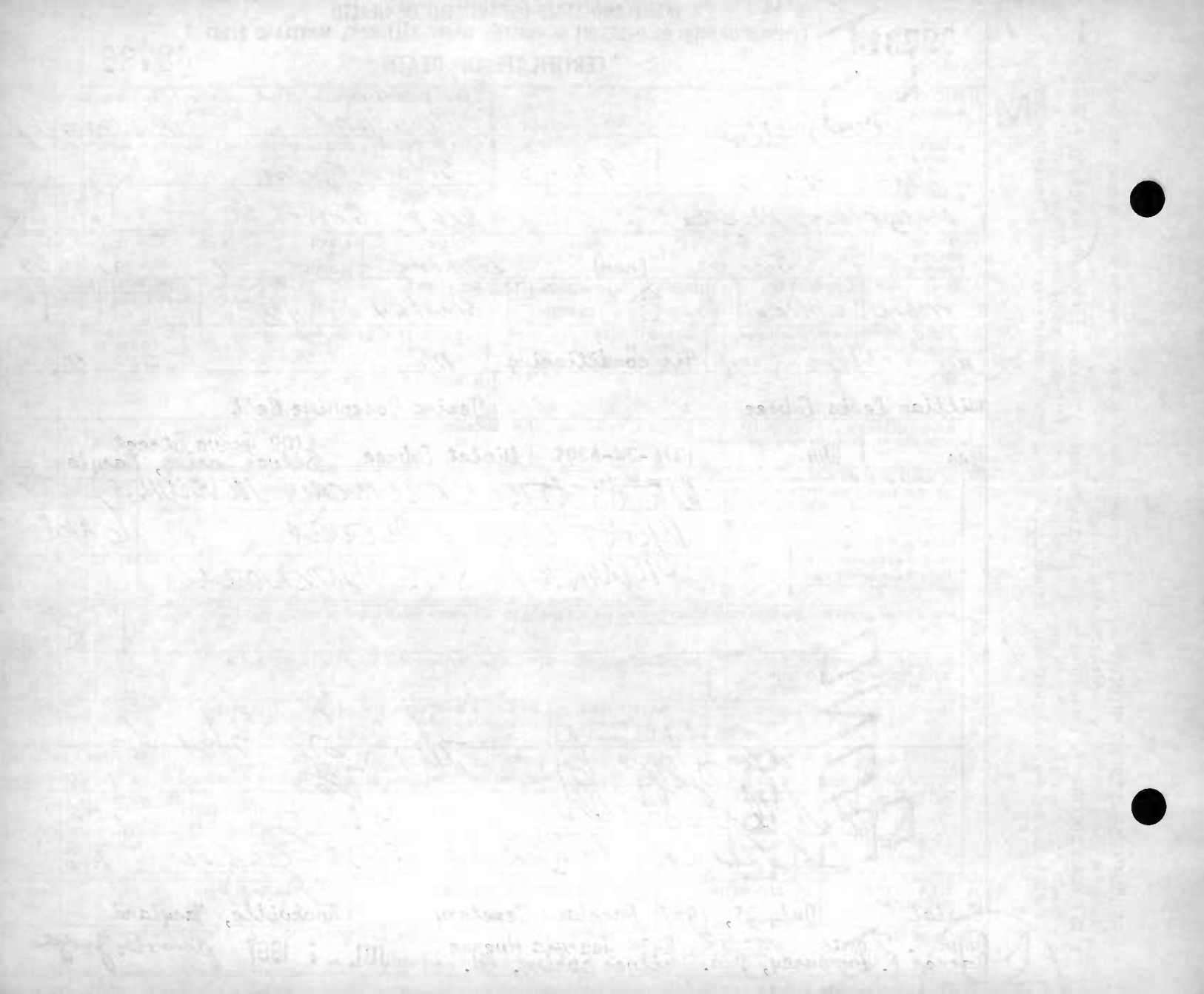
210

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | c. LENGTH OF STAY IN lb
<u>9 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | d. STREET ADDRESS
<u>8109 Grove St.</u> | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>Joseph (nmn) Embree</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>21</u> Year <u>1967</u> | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/31/44</u> |
| 9. AGE (In years lost birthday)
<u>23</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>air conditioning engr.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Air conditioning</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Mo.</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>William Lewis Embree</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Jemima Josephine Bell</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWII</u> | |
| 16. SOCIAL SECURITY NO.
<u>218-24-6295</u> | | 17. INFORMANT
<u>Violet Embree</u> Address <u>8109 Grove Street Silver Spring, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA INVOLVING</u>
1992 DUE TO <u>RIGHT LUNG & PLEURA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>PRIMARY SITE UNKNOWN</u>
(b) <u> </u>
(c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/17</u> , 19 <u>67</u> to <u>7/21</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>7/21</u> , 19 <u>67</u> , and that death occurred at <u>7:15</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>David Colden</u> | | 22b. DATE SIGNED
<u>7/21/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>DAVID COLDEN</u> | | 22d. ADDRESS
<u>10620 Pardon Rd.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>July 25, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>John B. Thomas</u>
<u>Warner E. Pumphrey, Inc.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 27 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25c. ADDRESS
<u>8434 Georgia Avenue Silver Spring, Md.</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09732

Item #16 Film #G391 8/3/67 ph

CERTIFICATE OF DEATH

09737

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i>
c. LENGTH OF STAY IN 1b
<i>2 days</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Holy Cross Hospital</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<i>Maryland</i>
b. COUNTY
<i>Montgomery</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i>
d. STREET ADDRESS
<i>8211 Queen Annes Drive</i>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <i>Ethel</i> Middle <i>Dorothy</i> Last <i>Estep</i>
4. DATE OF DEATH
Month <i>July</i> Day <i>25</i> Year <i>19 67</i> | | 5. SEX
<i>female</i>
6. COLOR OR RACE
<i>white</i>
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH
<i>Nov 25, 1906</i>
9. AGE (In years last birthday) yrs.
<i>60</i>
IF UNDER 1 YEAR
Months Days Hours Min.
<i>25</i> <i>19</i> <i>67</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Telephone operator</i>
10b. KIND OF BUSINESS OR INDUSTRY
<i>U.S. Govt.</i>
11. BIRTHPLACE (County & State, or foreign country)
<i>Mass.</i>
12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 13. FATHER'S NAME
<i>Charles H. Thompson</i>
14. MOTHER'S MAIDEN NAME
<i>Margaret Phillips</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> <i>None</i>
16. SOCIAL SECURITY NO.
<i>577-01-28371</i>
17. INFORMANT
<i>Lewis Estep</i>
Address
<i>8211 Queen Annes Drive Silver Spring, Maryland</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4201</i> DUE TO <i>Cerebral Hemorrhage</i> <i>2 days</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO <i>Myocardial Infarction</i> <i>2 days</i>
(c) <i>Myocardial Infarction</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<i>Atherosclerosis, Generalized</i>
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20c. TIME OF INJURY Month, Day, Year
Hour o.m. <i>19</i> p.m.
20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from <i>Feb 5, 1964</i> to <i>July 25, 1967</i> that (I) (we) last saw the deceased alive on <i>July 25, 1967</i> and that death occurred on <i>July 25, 1967</i> at <i>4:45 PM</i> , from causes and on the date stated above. | |
| 22a. SIGNATURE
<i>John J. Curry</i>
22c. PHYSICIAN'S NAME (Type)
<i>John J. Curry</i> | | 22b. DATE SIGNED
<i>7/25/67</i>
M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22d. ADDRESS
<i>10620 Georgia Ave Silver Spring, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i>
23b. DATE THEREOF
<i>July 28, 1967</i>
23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill Cemetery</i>
23d. LOCATION (City or Town) (County) (State)
<i>Suitland, Maryland</i> | | 24. FUNERAL DIRECTOR
<i>Warner E. Pumphrey, Inc.</i>
ADDRESS
<i>8434 Georgia Avenue Silver Spring, Md.</i>
25a. REC'D BY REGISTRAR
DATE <i>JUL 31 1967</i>
25b. REGISTRAR'S SIGNATURE
<i>Charles Jones</i> | |

1. 2. 3.

09733

CERTIFICATE OF DEATH

09738

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | |
| c. LENGTH OF STAY IN 1b
<u>15 days</u> | | d. STREET ADDRESS
<u>1804 BELVEDERE BLVD</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Norma</u> Middle <u>W</u> Last <u>FARLEY</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/19/15</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>CHICK -</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>U.S. GOVT</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>DASH. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>FRED T. WATSON SR.</u> | | 14. MOTHER'S MARDEN NAME
<u>EMILY A. GLADMON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>SEE # 2</u> | |
| 17. INFORMANT
<u>EDWARD F. FARLEY JR.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral infarction right temporal lobe</u>
DUE TO
(b) <u>Thrombotic occlusion of: right vertebral artery</u>
DUE TO
(c) <u>right subclavian artery</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Status post right subclavian innominate endarterectomy</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MAY</u> , 19 <u>65</u> , to <u>7-6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-6</u> 19 <u>67</u> , and that death occurred at <u>1120 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Francis Mayle, M.D.</u> | | 22b. DATE SIGNED
<u>7/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Francis Mayle, M.D.</u> | | 22d. ADDRESS
<u>8218 Wisconsin Ave. Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/11/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Seitland MD</u> | |
| 24. FUNERAL DIRECTOR
<u>W.W. Chambers Co. Sil. Spring MD.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 11 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

CERTIFICATE OF DEATH

09739

09734

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|---|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda (rural)</u> | | | c. LENGTH OF STAY IN 1b
<u>1 day</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Naval Hospital</u> | | | | d. STREET ADDRESS
<u>5169 Watson Street, N. W.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>William</u> Middle <u>Morrow</u> Last <u>Fechteler</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>4</u> Year <u>19 67</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Cauc</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>March 6, 1896</u> | |
| 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>U. S. Navy - Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>- - -</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>San Rafael, California</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 13. FATHER'S NAME
<u>Augustus Fechteler</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Maud Morrow</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Yes 1912-1956</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>- - -</u> | | | | 17. INFORMANT <u>N.W., Washington</u> Address <u>D. C.</u>
<u>Mrs. Goldye S. Fechteler, 5169 Watson Street</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Dissecting aortic aneurysm</u>
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (X) (this hospital) attended the deceased from <u>July 4</u> , 19 <u>67</u> , to <u>July 4</u> , 19 <u>67</u> , that (X) (we) last saw the deceased alive on <u>July 4</u> , 19 <u>67</u> , and that death occurred at <u>6:45 P.M.</u> from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>William R. Hix</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>5 July 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>William R. Hix, M. D.</u> | | | | 22d. ADDRESS
<u>Naval Hospital, Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7-7-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Arlington, Virginia</u> | |
| 24. FUNERAL DIRECTOR: <u>Joseph Gawler & Sons</u> ADDRESS
<u>5130 Wisconsin Ave., N.W. Washington, D. C.</u> | | | | 25a. REC'D BY REGISTRAR
<u>JUL 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|--|-----------------------------------|
| 09735 | | 09740 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bechtelsville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u> | |
| c. LENGTH OF STAY IN 1b <u>6 days</u> | | 30.4 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Luburn</u> | | d. STREET ADDRESS <u>Ashtabuck Rd. Home</u> | |
| 3. NAME OF DECEASED
(Type or print) First <u>Rosa</u> Middle <u>Feldhaus</u> Last <u>Feldhaus</u> | | 4. DATE OF DEATH Month <u>7</u> Day <u>3</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/20/1867</u> |
| 9. AGE (In years last birthday) <u>100</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>homemaker</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Wright</u> | | 14. MOTHER'S MAIDEN NAME <u>unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Clarence Swann</u> | | Address <u>260N. 11st. Neward N.J.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4200 congestive failure</u>
DUE TO (b) <u>ASH</u>
DUE TO (c) <u>ASH</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>
<u>no</u> <u>yes</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Bronchopneumonia</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/29</u> , 19 <u>67</u> , to <u>7/3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/3</u> , 19 <u>67</u> , and that death occurred at <u>7:50</u> P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Garvin Wadler</u> M.D. | | 22b. DATE SIGNED <u>7/13/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>GARVIN WADLER</u> | | 22d. ADDRESS <u>8218 Wisc. Av. Beth., Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/7/1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemt.</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Wm. J. Tickner & Son</u> | | 25a. REC'D BY REGISTRAR <u>Ben C. L. Smith</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>J. Charles Young</u> | | DATE <u>JUL 7 1967</u> | |

Ken

051 528/56W

1111

• Job Interview •

1. 1. 1.

3/1/51

• 60 e Ellipse -

TO HOSPITAL OR TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09736

09741

| | | | |
|--|-------------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE <u>Ind</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>3 years</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1601 Bristow St</u> | | d. STREET ADDRESS <u>1601 Bristow St</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>JEANNETTE G.</u> Middle <u>Fennell</u> Last <u>Fennell</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>29</u> Year <u>1967</u> | |
| S. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH <u>Feb. 11, 1926</u> |
| 9. AGE (In years last birthday) <u>41</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AW</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Guy A. Guiffre</u> | | 14. MOTHER'S MAIDEN NAME <u>FRANCES HARR</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>FRANK Fennell #2</u> | | Address <u> </u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma Breast metastases</u>
DUE TO <u>170X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last.
(b) <u> </u>
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>8/66</u> 19 <u> </u> to <u>7/29/67</u> 19 <u> </u> , that (I) <u>live</u> last saw the deceased alive on <u>7/27/67</u> 19 <u> </u> , and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Henry C. Scruggs MD</u> | | 22b. DATE SIGNED <u>7/29/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD</u> | | 22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>Aug 1, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>GATE OF HEAVEN</u> | | 23d. LOCATION (City, town, or county) <u>Wheaton, Ind</u> (State) <u> </u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Attanelli</u> | | 25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| ADDRESS <u>14th St NW 2000</u> | | DATE <u>JUL 31 1967</u> | |

CERTIFICATE OF DEATH

138

Prophet

See page

See page

See page 11

See page

See page

See page

See page

See page

See page

See page

See page

See page

See page

See page

See page

See page

See page

See page

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|----------------------------------|---|-----------------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
-- DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General Hospital | | d. STREET ADDRESS
Box 97, 26008 Ridge Rd. | |
| 3. NAME OF DECEASED
(Type or print) Carroll K. Fetzer | | 4. DATE OF DEATH
Month 7 Day 20 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/9/96 |
| 9. AGE (In years last birthday) yrs.
71 | | 10. IF UNDER 1 YEAR Months Days Hours Min.
71 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Machinist | | 10b. KIND OF BUSINESS OR INDUSTRY
Naval Gun Factory | |
| 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
William Fetzer | | 14. MOTHER'S MAIDEN NAME
Minnie Koser | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes W.W.I | | 16. SOCIAL SECURITY NO.
579-09-7977 | |
| 17. INFORMANT
Hospital Records, Olney, Maryland | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Rupture - abdominal aneurysm
DUE TO (b) ASCVD
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH
15 min | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jan , 1967, to July 21 , 1967, that (I) (we) last saw the deceased alive on July 16 , 1967, and that death occurred at 7:05 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Frederick Moomau M.D. | | 22b. DATE SIGNED
7-21-67 | |
| 22c. PHYSICIAN'S NAME (Type)
Frederick Moomau | | 22d. ADDRESS
Olney, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 23, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Damascus Meth. | | 23d. LOCATION (City or Town) (County) (State)
Damascus, Md. | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, Md. | | 25a. REC'D BY REGISTRAR
JUL 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Jones | | | |

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
OFFICE OF THE REGISTRAR
ALBANY, N. Y.

DATE OF BIRTH: 1900

SEX: M

AGE: 10

PLACE OF BIRTH: N. Y.

NAME: JAMES

ON

DATE: JULY 25, 1900

JULY 25, 1900

OFFICE: ALBANY, N. Y.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09738

09743

| | | | | | | | |
|--|--|------------------------------|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> | | | |
| c. LENGTH OF STAY IN 1b <u>16 days</u> | | | | d. STREET ADDRESS <u>8950 Gue Rd</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mont. County Gen Hosp</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Bennett F. Fishpaw</u> | | | | 4. DATE OF DEATH <u>July 1, 1967</u> | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>Cauc</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7-12-12</u> | |
| 9. AGE (In years last birthday) <u>54 yrs.</u> | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Cockeysville, Md.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>Malcolm Fishpaw</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Maggie Parks</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | | |
| 16. SOCIAL SECURITY NO. <u>W.W. # 2 218-05-6111</u> | | | | 17. INFORMANT <u>Mrs Cathryne Fishpaw, Item 2</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pulmonary Edema</u>
4221 DUE TO (b) <u>Acute Myocardial Dis.</u>
DUE TO (c) <u>Generalized Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2-3 hrs</u>
<u>3 days</u>
<u>4 yrs.</u> |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John S. Rogers</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>John S. Rogers</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | 22. DATE SIGNED <u>July 1, 1967</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 23b. DATE THEREOF <u>July 4, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Damascus Meth.</u> | |
| 23d. LOCATION (City, town or county) (State) <u>Damascus, Md.</u> | | | | | | | |
| 24. FUNERAL DIRECTOR <u>Olin L. Molesworth</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 6 1967</u> | | | |
| ADDRESS <u>Damascus, Md.</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

STATE OF NEW YORK
MEDICAL EXAMINER
CERTIFICATE OF DEATH

1935

Cornwall, N.Y.

Albany, N.Y.

Albany, N.Y.

Albany, N.Y.

For N.Y.S. 518-02-011

See Bureau of Health, Albany, N.Y.

John A. Hoffmann, M.D.

Albany, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09739

CERTIFICATE OF DEATH

09744

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b <u>62 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> 151 |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | d. STREET ADDRESS <u>204 Primrose St. Rm 151</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Martha Elizabeth Florence</u> | | 4. DATE OF DEATH <u>7 - 1</u> 19 <u>67</u> | |
| 5. SEX <u>female</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-19-03</u> |
| 9. AGE (In years last birthday) <u>64</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u> IF UNDER 24 HRS. Hours <u>19</u> Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Charles Clark</u> | | 14. MOTHER'S MAIDEN NAME <u>Florence Conover</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u> (If yes give war or dates of service) <u>233883605</u> | | 16. SOCIAL SECURITY NO. <u>213-38-3605</u> | |
| 17. INFORMANT <u>Hospital Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute heart failure</u>
DUE TO (b) <u>CVA</u>
DUE TO (c) <u>arteritis</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>4 dys</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastric Ulcer</u> <u>Rheumatoid Arthritis</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
White <input type="checkbox"/> Not white <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>4-30</u> , 19 <u>67</u> , to <u>7-1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6-30</u> , 19 <u>67</u> , and that death occurred at <u>5⁴⁰</u> AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>R. H. Sandstrom MD</u> | | 22b. DATE SIGNED <u>7-1-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>R. H. Sandstrom MD</u> | | 22d. ADDRESS <u>7701 Carroll Ave Takoma Park, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7/3/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co. Md.</u> |
| 24. FUNERAL DIRECTOR <u>The S. H. Hines Co</u> | | 25a. REC'D BY REGISTRAR <u>2901-14th St. N.W.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | DATE <u>JUL 3 1967</u> | |

VR A15 (4)
25M 1/67

1948
JANUARY 10
MEMORANDUM
TO: THE SECRETARY OF THE ARMY
FROM: THE CHIEF OF THE ARMY
SUBJECT: [Illegible]
[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page.]

CERTIFICATE OF DEATH

09740

09745

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

| | | | | | | | | |
|--|--|-------------------------------------|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | c. LENGTH OF STAY IN 1b
<u>4 days</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Adelphi</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hosp.</u> | | | | d. STREET ADDRESS
<u>7906 West park dr.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Svend</u> Middle <u>E</u> Last <u>Frederiksen</u> | | | | 4. DATE OF DEATH
Month <u>7</u> Day <u>20</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>M.</u> | | 6. COLOR OR RACE
<u>W.</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>8-31-06</u> | | |
| | | | | 9. AGE (In years lost birthday)
<u>60</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>ESKIMOLOGIST</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>SELF-EMPLOYED</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>DENMARK</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>OLSEN FREDERIKSON</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>UNKNOWN</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>NO</u> | | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u>WM. A. HILLMAN, SON-IN-LAW</u> | | | |
| | | | | | | Address <u>Takoma Park, Md. 38 Columbia Ave.</u> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>464X</u> IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u>
DUE TO (b) <u>Thrombophlebitis</u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-16</u> , 19 <u>67</u> , to <u>7-20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-20</u> 19 <u>67</u> , and that death occurred at <u>7:50 P.</u> M, from causes and on the date stated above. | | | | | | | | |
| 22a. SIGNATURE
<u>R. Longoria, M.D.</u> | | | | 22b. DATE SIGNED
<u> </u> | | 22c. PHYSICIAN'S NAME (Type)
<u>R. Longoria, M.D.</u> | | |
| | | | | 22d. ADDRESS
<u>8402 Fenton St, Silver Sp. Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/22/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Williams</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Ft. Royal Virginia</u> | | |
| 24. FUNERAL DIRECTOR
<u>GASCH'S</u> | | | | ADDRESS
<u>HYATTSVILLE, MARYLAND</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 24 1967</u> | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | |

532

CERTIFICATE OF DEATH

09721

09746

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>PRINCE GEORGES</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TAKOMA PARK</u> | | c. LENGTH OF STAY IN 1b
<u>6 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>WASHINGTON SAN. & HOSPITAL</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>GRAHAM CRAWFORD FULLER</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>30</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>WH</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/29/19K</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>MEAT PK., CO</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>ILLINOIS</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>EDWARD S. FULLER, JR.</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>EMMA L. SCHUTTLER</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>578-09-9477</u> | |
| 16. SOCIAL SECURITY NO.
<u>578-09-9477</u> | | 17. INFORMANT
<u>HOSPITAL RECORDS</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of Lung with metastases</u>
169X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) DUE TO
(c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 yr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 25, 1967, to July 30, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 30, 1967</u> , and that death occurred at <u>4:00 PM</u> , from causes and on the date stated above | | | |
| 22a. SIGNATURE
<u>[Signature]</u> M.D. | | 22b. DATE SIGNED
<u>7-30-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS
<u>7712 Annapole Takoma Park</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>8-2-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Congressional Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR
<u>Lee Funeral Home Washington DC</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AUG 2 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH

IN SENATE
January 11, 1911
REPORT OF THE
COMMISSIONER OF HEALTH
FOR THE YEAR 1910
ALBANY: J.B. LIPPINCOTT & CO., PRINTERS
1911

CERTIFICATE OF DEATH

09742

09747

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>xx1002 Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. LENGTH OF STAY IN tb <u>3 Months</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>13107 Dumbarton Drive</u> | | d. STREET ADDRESS <u>13107 Dumbarton Drive</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Mary Elizabeth Galks</u> | | 4. DATE OF DEATH <u>July 26, 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 21, 1902</u> |
| 9. AGE (In years last birthday) <u>65</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph Luckman</u> | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Eligabeth Gressley</u> | | Address <u>13107 Dumbarton Drive</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
DUE TO (b) <u>Atherosclerosis</u>
DUE TO (c) <u>Hypertensive Cardiovascular Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>undetermined</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 15</u> , 19 <u>66</u> , to <u>July 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 26</u> , 19 <u>67</u> , and that death occurred at <u>1 P</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stanley M. Bialek</u> | | 22b. DATE SIGNED <u>26 July 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Stanley M. Bialek</u> | | 22d. ADDRESS <u>8218 Wisconsin Ave. Bethesda, Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 31, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Nantux Glo Pa.</u> |
| 24. FUNERAL DIRECTOR <u>Warner E. Pumphrey Inc.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 31 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Clark E. Wisor</u> | | 25c. ADDRESS <u>Silver Spring, Md.</u> | |

1975

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

Washington, D.C.

1975

1975

1975

1975

Mary Elizabeth

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

1975

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

09743

09748

| | | | | | | | |
|--|------------------------------|---|-------------------------------------|---|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. LENGTH OF STAY IN 1b
<u>1 month</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium - Hospital</u> | | | | d. STREET ADDRESS
<u>40 Philadelphia Ave</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Dario</u> Middle <u>(None)</u> Last <u>Garcia</u> | | | | 4. DATE OF DEATH
Month <u>7</u> Day <u>28</u> Year <u>1967</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
<u>11-29-12</u> | | 9. AGE (In years last birthday)
<u>54</u> yrs. | IF UNDER 1 YEAR
Months <u>5</u> Days <u>4</u> | IF UNDER 24 HRS.
Hours <u>1</u> Min. <u>0</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Interpreter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Brazil</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>Brazil</u> | |
| 13. FATHER'S NAME
<u>Lino Garcia</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Leopoldina Dochorn</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | 17. INFORMANT
<u>Hospital Records</u> Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>157X</u> IMMEDIATE CAUSE (a) <u>TOXEMIA</u>
DUE TO (b) <u>ASSOCIATED WITH JAUNDICE AND PERITONITIS</u>
DUE TO (c) <u>CARCINOMA OF PANCREAS</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>100 days</u>
<u>10 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1967</u> to <u>July 28, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 28, 1967</u> , and that death occurred at <u>11:45 AM</u> , from causes on and the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>W. W. Eastman</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>7-28-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
<u>July 31-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>East Lincoln</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Hagerstown, Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Arthur Walters</u> | | | | 25a. REC'D BY REGISTRAR
<u>254 Capitol St. N.W.</u>
<u>Washington D.C.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

DATE JUL 31 1967

STATE OF OHIO

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

1880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

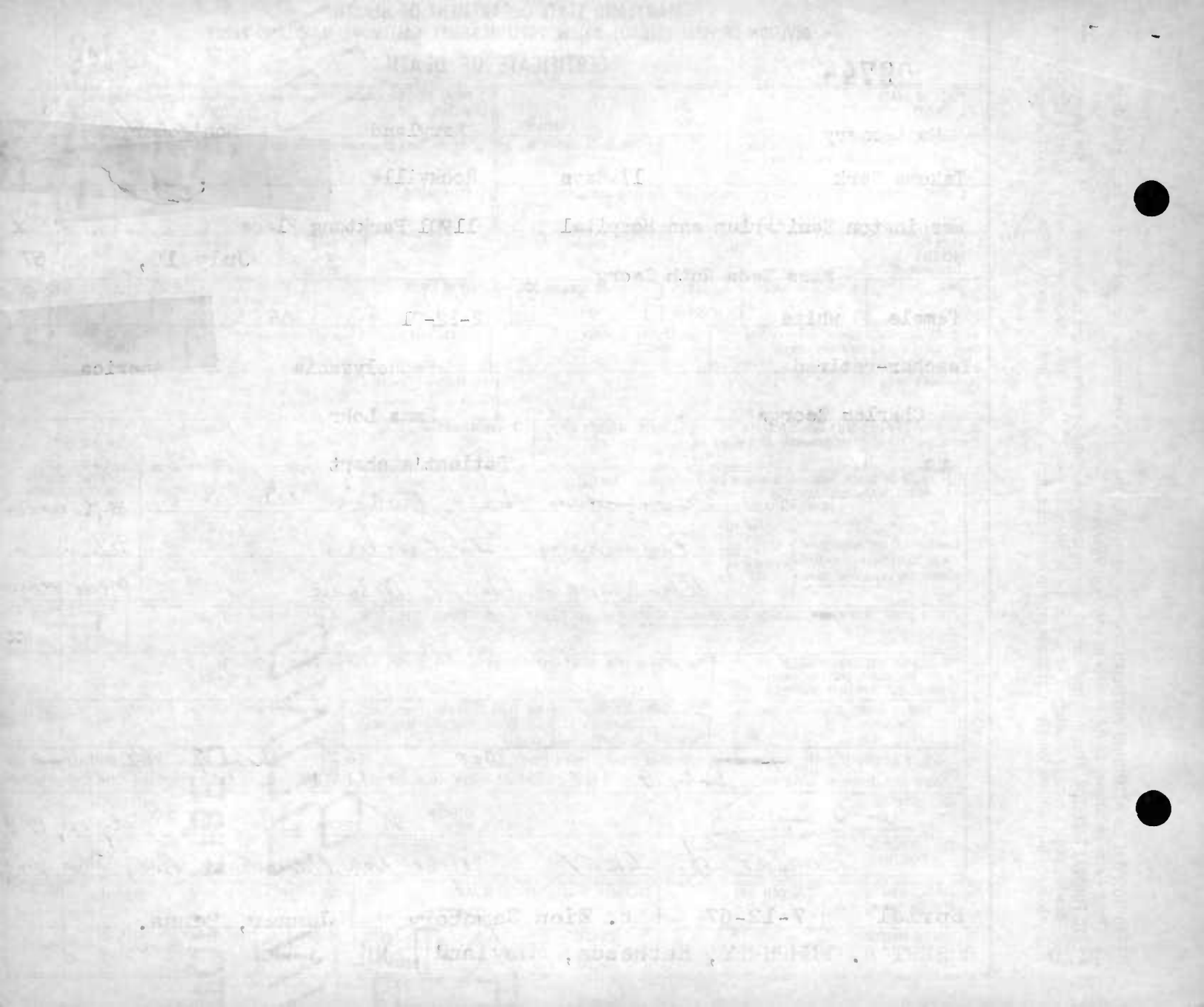
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09744

09749

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
c. LENGTH OF STAY IN IL
17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium and Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rockville
d. STREET ADDRESS
11901 Parktong Place
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Miss Zeda Ruth Georg
First Middle Last | | 4. DATE OF DEATH
July 10, 1967
Month Day Year | |
| 5. SEX
female | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
2-12-01
9. AGE (In years lost birthday) yrs.
66 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Teacher-retired | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
Pennsylvania |
| 12. CITIZEN OF WHAT COUNTRY?
America | | 13. FATHER'S NAME
Charles George | |
| 14. MOTHER'S MAIDEN NAME
Emma Lohr | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
Patient's chart
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4/67 Congestive Heart Failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Pulmonary Infarction
DUE TO
(c) Rheumatic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
3 1/2 weeks
3 1/2 weeks
Many years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct , 1962, to July 9 , 1967, that (I) (we) last saw the deceased alive on July 9 , 1967, and that death occurred at 12:30 AM, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Robert D. Irey | | 22b. DATE SIGNED
July 10, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT D. IREY | | 22d. ADDRESS
11161 New Hampshire Ave, Silver Spring | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-12-67 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Cemetery | 23d. LOCATION (City or Town) (County) (State)
Jenner, Penna. |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
DATE JUL 13 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|-------------------------------------|---|---|--|--|---|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 09745 CERTIFICATE OF DEATH 09750 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Mont.</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North Chevy Chase</u> | | | c. LENGTH OF STAY IN 1b
<u>30 years</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North Chevy Chase 151</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>8809 Kensington Parkway</u> | | | | | d. STREET ADDRESS
<u>8809 Kensington Pkwy</u> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Laura McChesney Gilliland</u> | | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>8</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>F</u> | | 6. COLOR OR RACE
<u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 27, 1886</u> | | 9. AGE (In years last birthday) yrs. <u>81</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Secretary</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Retired</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>James Gilliland</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Alice McChesney</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | 16. SOCIAL SECURITY NO.
<u>578-01-0772</u> | | 17. INFORMANT <u>Sister</u> <u>Same as Item 2.</u>
<u>Mary Elizabeth Gilliland</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4200 IMMEDIATE CAUSE (a) <u>Myocardial failure</u>
DUE TO (b) <u>Arteriosclerotic heart disease</u>
DUE TO (c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
<u>None</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u></u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>66</u> , to <u>present</u> , that (I) (we) lost saw the deceased alive on <u>7/6</u> 19 <u>67</u> , and that death occurred at <u>5P</u> M, from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>John B. Umhau</u> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>7/8/67</u> | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN B. UMHAN MD</u> | | | | | 22d. ADDRESS
<u>8805 Conn. Ave. Chevy Chase Md</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7-11-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rock Creek Cemetery</u> | | | 23d. LOCATION (City or town) (County) (State)
<u>Washington, D. C.</u> | | |
| 24. FUNERAL DIRECTOR
<u>Robert A. Pumphrey, Bethesda, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 13 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

0075

OFFICE OF THE

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C.

May 1, 1954

Memorandum

For the Director

James O. Eastland

Miss Katherine

Room 4000

100-1-0712

7-11-57

Robert A. Murphy, Bethesda, Maryland

09751

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09751

CERTIFICATE OF DEATH

09746

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CHRYL CHASE</u> | c. LENGTH OF STAY IN 1b
<u>9/28/66 - 7-22-67</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>BETHESDA SILVER SPRING NURSING HOME</u> | d. STREET ADDRESS
<u>9505 Saybrook Ave.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) <u>A. D. KRA</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>CAUC.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>3/7/1888</u> |
| 9. AGE (In years lost birthday) yrs.
<u>79</u> | | IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>WEST CHESTER CAMBRIDGE, OHIO</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Dave Wilson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Saviors</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>216507054</u> | |
| 17. INFORMANT
<u>Mary Louise Brown</u> | | Address
<u>126 Normandy Drive Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage Massive</u>
DUE TO (b) <u>Cerebro-Sclerosis</u>
DUE TO (c) <u>Cerebral Thromboses Multiple</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Since 1962</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Generalized Arterio-sclerosis - Hypertensive Heart Disease</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>No</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u></u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u></u> | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 17, 1953</u> to <u>July 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 13, 1967</u> , and that death occurred at <u>7:30 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>George L Ball</u> | | 22b. DATE SIGNED
<u>July 22, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>George L Ball</u> | | 22d. ADDRESS
<u>10620 Georgia Avenue Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>July 25, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Rockville, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>John S. Thomas John S. Thomas Warner E. Pumphrey, Inc.</u> | | ADDRESS
<u>8434 Georgia Avenue Silver Spring, Md.</u> | |
| 25a. REC'D BY REGISTRAR
DATE <u>JUL 25 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Juergen</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

EXTRACT OF DEED

1870
JULY 2 1870

State of

County of

Section 36

Range 10

North 36th

Section 36

Range 10

Section 36

Range 10

JUL 2 1870

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LANDS
WASHINGTON, D. C.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office planned with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

Items 18-21 Film 391 8-3 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09747

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09752

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN 1b
DOA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General Hospital | | d. STREET ADDRESS
Rt. 2, Gaithersburg, Md. 15-1 | |
| 3. NAME OF DECEASED
(Type or print)
Robert Charles Goad | | 4. DATE OF DEATH
Month 7 Day 20 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
6/25/38 |
| 9. AGE (In years last birthday) yrs.
29 | | 10. IF UNDER 1 YEAR
Months 20 Days 19 Hours 67 Min. | |
| 11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mechanic | | 11b. KIND OF BUSINESS OR INDUSTRY
Montgomery County | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | 13. BIRTHPLACE (State or foreign country)
Washington, D. C. | |
| 13. FATHER'S NAME
Floyd Goad | | 14. MOTHER'S MAIDEN NAME
Anna Kahl | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-34-4301 | |
| 17. INFORMANT
Wife, Betty Goad, | | Address
Gaithersburg, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
8161
IMMEDIATE CAUSE (a) Multiple extreme injuries including
DUE TO
(b) fractured skull and exsanguination
DUE TO
(c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Deceased driving vehicle which collided with truck. | |
| 20c. TIME OF INJURY Month, Day, Year
7:25 p.m. 7/20/ 19 67 | | 20d. INJURY OCCURRED 2
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Street | | 20f. (City or town) (County) (State)
Damascus Montgomery Md. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
Belden R. Reap
EXAMINER'S NAME (Type)
BELDEN R. REAP M.D. | | 22. DATE SIGNED
7/21/1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-24-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Mt. Tabor | | 23d. LOCATION (City or Town) (County) (State)
Etchison Mont. Md. | |
| 24. FUNERAL DIRECTOR
Francis H. Barber Laytonsville, Md. | | 25a. REC'D BY REGISTRAR
DATE JUL 25 1967 | |
| 25b. REGISTRAR'S SIGNATURE
gcharles juaze | | | |

Stebbins House, Md.

Mr. Labor

7-21-07

General

Francis H. Barker, Baltimore, Md.

July 21, 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 09748 | | 09753 | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY
c. LENGTH OF STAY IN 1b 13 DAYS | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MONTGOMERY GENERAL HOSPITAL | | d. STREET ADDRESS 16 Thomas St.
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First DOROTHY Middle SAVIERS Last GONZALEZ | | 4. DATE OF DEATH
Month 7 Day 26 Year 19 67 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 7-31-97
9. AGE (In years last birthday) 69 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED | | 10b. KIND OF BUSINESS OR INDUSTRY CIVIL SERVICE | 11. BIRTHPLACE (County & State, or foreign country) INDIANA |
| 13. FATHER'S NAME GEORGE SAVIERS | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 315-18-7997 | 17. INFORMANT MEDICAL RECORD DEPT.
Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarct
DUE TO (b) Occlusion, Rt. Coronary artery
DUE TO (c) Arteriosclerotic Heart disease | | | INTERVAL BETWEEN ONSET AND DEATH
days
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) | |
| 20c. TIME OF INJURY
Hour a.m. Month, Day, Year 19 67
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Oct. 1966 to July 26, 1967 , that (I) (we) lost saw the deceased alive on July 25, 1967 , and that death occurred at 11:10 A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE Frederick Moomau, M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED 7-27-67 |
| 22c. PHYSICIAN'S NAME (Type) FREDERICK MOOMAU, M. D. | | 22d. ADDRESS MEDICAL CENTER, SANDY SPRING, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation | 23b. DATE THEREOF 7/28/67 | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill | 23d. LOCATION (City or Town) (County) (State) Prince George Co., Md. |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike | | 25a. REC'D BY REGISTRAR JUL 31 1967
DATE
25b. REGISTRAR'S SIGNATURE James J. J... | |

THE STATE OF OHIO

WYOMING

HAYLAND

HONOLULU

ROCKWELL

17 DATE

17 MAY

17 MAY 1967

HONOLULU GENERAL HOSPITAL

17 MAY 1967

17 MAY 1967

17 MAY 1967

17

17-19-67

X

WHITE

WHITE

INDIANA

CIVIL SERVICE

17 MAY 1967

17 MAY 1967

17 MAY 1967

17 MAY 1967

17 MAY 1967

17

17 MAY 1967

17 MAY 1967

17 MAY 1967

X

17 MAY 1967

17

17 MAY 1967

17 MAY 1967

17 MAY 1967

17 MAY 1967

17 MAY 1967

17 MAY 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 09749 CERTIFICATE OF DEATH 09754 | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN 1b
<u>151</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Potomac Valley Nursing Home</u> | | e. STREET ADDRESS
<u>7524 Hampden Lane</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Mary</u> Middle <u>F</u> Last <u>Goodwin</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-26-89</u> |
| 9. AGE (In years lost birthday)
<u>77</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min.
<u>77</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maine</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U. S.</u> | |
| 13. FATHER'S NAME
<u>Edward P. Dore</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah F. Patten</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>Virginia G. Rolnick</u> | |
| 17. INFORMANT
<u>Daughter</u> | | Address
<u>Same as Item 2.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-respiratory Failure</u>
DUE TO
(b) <u>Carcinomatosis</u>
DUE TO
(c) <u>Ca. Head of Pancreas</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>8 hrs</u>
<u>6 mos</u>
<u>1 yr.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> <u>19</u>
p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1957</u> to <u>29 June, 1967</u> , that (I) (we) last saw the deceased alive on <u>28 June 1967</u> , and that death occurred at <u>4:00 P.</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John M. Wyman</u> | | 22b. DATE SIGNED
<u>7/30/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN M. WYMAN</u> | | 22d. ADDRESS
<u>7801 Norfolk Ave. Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>8-2-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Oak Hill Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Washington, D. C.</u> |
| 24. FUNERAL DIRECTOR
<u>Robert A. Pumphrey, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR
<u>AUG 3 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

REPORT OF THE

1914

| No. | | Name | | Address | | City | | State | | Country | |
|-----|--|-----------|--|---------|--|------|--|-------|--|---------|--|
| 1 | | J. H. ... | | ... | | ... | | ... | | ... | |
| 2 | | ... | | ... | | ... | | ... | | ... | |
| 3 | | ... | | ... | | ... | | ... | | ... | |
| 4 | | ... | | ... | | ... | | ... | | ... | |
| 5 | | ... | | ... | | ... | | ... | | ... | |
| 6 | | ... | | ... | | ... | | ... | | ... | |
| 7 | | ... | | ... | | ... | | ... | | ... | |
| 8 | | ... | | ... | | ... | | ... | | ... | |
| 9 | | ... | | ... | | ... | | ... | | ... | |
| 10 | | ... | | ... | | ... | | ... | | ... | |
| 11 | | ... | | ... | | ... | | ... | | ... | |
| 12 | | ... | | ... | | ... | | ... | | ... | |
| 13 | | ... | | ... | | ... | | ... | | ... | |
| 14 | | ... | | ... | | ... | | ... | | ... | |
| 15 | | ... | | ... | | ... | | ... | | ... | |
| 16 | | ... | | ... | | ... | | ... | | ... | |
| 17 | | ... | | ... | | ... | | ... | | ... | |
| 18 | | ... | | ... | | ... | | ... | | ... | |
| 19 | | ... | | ... | | ... | | ... | | ... | |
| 20 | | ... | | ... | | ... | | ... | | ... | |
| 21 | | ... | | ... | | ... | | ... | | ... | |
| 22 | | ... | | ... | | ... | | ... | | ... | |
| 23 | | ... | | ... | | ... | | ... | | ... | |
| 24 | | ... | | ... | | ... | | ... | | ... | |
| 25 | | ... | | ... | | ... | | ... | | ... | |
| 26 | | ... | | ... | | ... | | ... | | ... | |
| 27 | | ... | | ... | | ... | | ... | | ... | |
| 28 | | ... | | ... | | ... | | ... | | ... | |
| 29 | | ... | | ... | | ... | | ... | | ... | |
| 30 | | ... | | ... | | ... | | ... | | ... | |
| 31 | | ... | | ... | | ... | | ... | | ... | |
| 32 | | ... | | ... | | ... | | ... | | ... | |
| 33 | | ... | | ... | | ... | | ... | | ... | |
| 34 | | ... | | ... | | ... | | ... | | ... | |
| 35 | | ... | | ... | | ... | | ... | | ... | |
| 36 | | ... | | ... | | ... | | ... | | ... | |
| 37 | | ... | | ... | | ... | | ... | | ... | |
| 38 | | ... | | ... | | ... | | ... | | ... | |
| 39 | | ... | | ... | | ... | | ... | | ... | |
| 40 | | ... | | ... | | ... | | ... | | ... | |
| 41 | | ... | | ... | | ... | | ... | | ... | |
| 42 | | ... | | ... | | ... | | ... | | ... | |
| 43 | | ... | | ... | | ... | | ... | | ... | |
| 44 | | ... | | ... | | ... | | ... | | ... | |
| 45 | | ... | | ... | | ... | | ... | | ... | |
| 46 | | ... | | ... | | ... | | ... | | ... | |
| 47 | | ... | | ... | | ... | | ... | | ... | |
| 48 | | ... | | ... | | ... | | ... | | ... | |
| 49 | | ... | | ... | | ... | | ... | | ... | |
| 50 | | ... | | ... | | ... | | ... | | ... | |
| 51 | | ... | | ... | | ... | | ... | | ... | |
| 52 | | ... | | ... | | ... | | ... | | ... | |
| 53 | | ... | | ... | | ... | | ... | | ... | |
| 54 | | ... | | ... | | ... | | ... | | ... | |
| 55 | | ... | | ... | | ... | | ... | | ... | |
| 56 | | ... | | ... | | ... | | ... | | ... | |
| 57 | | ... | | ... | | ... | | ... | | ... | |
| 58 | | ... | | ... | | ... | | ... | | ... | |
| 59 | | ... | | ... | | ... | | ... | | ... | |
| 60 | | ... | | ... | | ... | | ... | | ... | |
| 61 | | ... | | ... | | ... | | ... | | ... | |
| 62 | | ... | | ... | | ... | | ... | | ... | |
| 63 | | ... | | ... | | ... | | ... | | ... | |
| 64 | | ... | | ... | | ... | | ... | | ... | |
| 65 | | ... | | ... | | ... | | ... | | ... | |
| 66 | | ... | | ... | | ... | | ... | | ... | |
| 67 | | ... | | ... | | ... | | ... | | ... | |
| 68 | | ... | | ... | | ... | | ... | | ... | |
| 69 | | ... | | ... | | ... | | ... | | ... | |
| 70 | | ... | | ... | | ... | | ... | | ... | |
| 71 | | ... | | ... | | ... | | ... | | ... | |
| 72 | | ... | | ... | | ... | | ... | | ... | |
| 73 | | ... | | ... | | ... | | ... | | ... | |
| 74 | | ... | | ... | | ... | | ... | | ... | |
| 75 | | ... | | ... | | ... | | ... | | ... | |
| 76 | | ... | | ... | | ... | | ... | | ... | |
| 77 | | ... | | ... | | ... | | ... | | ... | |
| 78 | | ... | | ... | | ... | | ... | | ... | |
| 79 | | ... | | ... | | ... | | ... | | ... | |
| 80 | | ... | | ... | | ... | | ... | | ... | |
| 81 | | ... | | ... | | ... | | ... | | ... | |
| 82 | | ... | | ... | | ... | | ... | | ... | |
| 83 | | ... | | ... | | ... | | ... | | ... | |
| 84 | | ... | | ... | | ... | | ... | | ... | |

24 hours after death. Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death.
TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death. The law requires that the death certificate be executed 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
I
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
66
67
68
69
70
71
72
73
74
75
76
77
78
79
80
81
82
83
84
85
86
87
88
89
90
91
92
93
94
95
96
97
98
99
100
101
102
103
104
105
106
107
108
109
110
111
112
113
114
115
116
117
118
119
120
121
122
123
124
125
126
127
128
129
130
131
132
133
134
135
136
137
138
139
140
141
142
143
144
145
146
147
148
149
150
151
152
153
154
155
156
157
158
159
160
161
162
163
164
165
166
167
168
169
170
171
172
173
174
175
176
177
178
179
180
181
182
183
184
185
186
187
188
189
190
191
192
193
194
195
196
197
198
199
200
201
202
203
204
205
206
207
208
209
210
211
212
213
214
215
216
217
218
219
220
221
222
223
224
225
226
227
228
229
230
231
232
233
234
235
236
237
238
239
240
241
242
243
244
245
246
247
248
249
250
251
252
253
254
255
256
257
258
259
260
261
262
263
264
265
266
267
268
269
270
271
272
273
274
275
276
277
278
279
280
281
282
283
284
285
286
287
288
289
290
291
292
293
294
295
296
297
298
299
300
301
302
303
304
305
306
307
308
309
310
311
312
313
314
315
316
317
318
319
320
321
322
323
324
325
326
327
328
329
330
331
332
333
334
335
336
337
338
339
340
341
342
343
344
345
346
347
348
349
350
351
352
353
354
355
356
357
358
359
360
361
362
363
364
365
366
367
368
369
370
371
372
373
374
375
376
377
378
379
380
381
382
383
384
385
386
387
388
389
390
391
392
393
394
395
396
397
398
399
400
401
402
403
404
405
406
407
408
409
410
411
412
413
414
415
416
417
418
419
420
421
422
423
424
425
426
427
428
429
430
431
432
433
434
435
436
437
438
439
440
441
442
443
444
445
446
447
448
449
450
451
452
453
454
455
456
457
458
459
460
461
462
463
464
465
466
467
468
469
470
471
472
473
474
475
476
477
478
479
480
481
482
483
484
485
486
487
488
489
490
491
492
493
494
495
496
497
498
499
500
501
502
503
504
505
506
507
508
509
510
511
512
513
514
515
516
517
518
519
520
521
522
523
524
525
526
527
528
529
530
531
532
533
534
535
536
537
538
539
540
541
542
543
544
545
546
547
548
549
550
551
552
553
554
555
556
557
558
559
560
561
562
563
564
565
566
567
568
569
570
571
572
573
574
575
576
577
578
579
580
581
582
583
584
585
586
587
588
589
590
591
592
593
594
595
596
597
598
599
600
601
602
603
604
605
606
607
608
609
610
611
612
613
614
615
616
617
618
619
620
621
622
623
624
625
626
627
628
629
630
631
632
633
634
635
636
637
638
639
640
641
642
643
644
645
646
647
648
649
650
651
652
653
654
655
656
657
658
659
660
661
662
663
664
665
666
667
668
669
670
671
672
673
674
675
676
677
678
679
680
681
682
683
684
685
686
687
688
689
690
691
692
693
694
695
696
697
698
699
700
701
702
703
704
705
706
707
708
709
710
711
712
713
714
715
716
717
718
719
720
721
722
723
724
725
726
727
728
729
730
731
732
733
734
735
736
737
738
739
740
741
742
743
744
745
746
747
748
749
750
751
752
753
754
755
756
757
758
759
760
761
762
763
764
765
766
767
768
769
770
771
772
773
774
775
776
777
778
779
780
781
782
783
784
785
786
787
788
789
790
791
792
793
794
795
796
797
798
799
800
801
802
803
804
805
806
807
808
809
810
811
812
813
814
815
816
817
818
819
820
821
822
823
824
825
826
827
828
829
830
831
832
833
834
835
836
837
838
839
840
841
842
843
844
845
846
847
848
849
850
851
852
853
854
855
856
857
858
859
860
861
862
863
864
865
866
867
868
869
870
871
872
873
874
875
876
877
878
879
880
881
882
883
884
885
886
887
888
889
890
891
892
893
894
895
896
897
898
899
900
901
902
903
904
905
906
907
908
909
910
911
912
913
914
915
916
917
918
919
920
921
922
923
924
925
926
927
928
929
930
931
932
933
934
935
936
937
938
939
940
941
942
943
944
945
946
947
948
949
950
951
952
953
954
955
956
957
958
959
960
961
962
963
964
965
966
967
968
969
970
971
972
973
974
975
976
977
978
979
980
981
982
983
984
985
986
987
988
989
990
991
992
993
994
995
996
997
998
999
1000

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
COUNTY <u>Montgomery</u> MARYLAND | | | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)
STATE <u>Maryland</u> COUNTY <u>Montgomery</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | | | | | | | | | | c. LENGTH OF STAY IN 1b
<u>3 years</u> | | | | | | | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> 15.1 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>8310 Draper Lane</u> | | | | | | | | | | | | d. STREET ADDRESS
<u>8310 Draper Lane</u> | | | | | | | | | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Virginia</u> First Middle Last | | | | | | | | | | | | 4. DATE OF DEATH
<u>July</u> Month <u>5</u> Day <u>19</u> Year <u>67</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX
<u>female</u> | | | | | | | | | | | | 6. COLOR OR RACE
<u>white</u> | | | | | | | | | | | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | | | 8. DATE OF BIRTH
<u>July 8, 1914</u> | | | | | | | | | | | | 9. AGE (In years last birthday)
<u>52</u> yrs. | | | | | | | | | | | | IF UNDER 1 YEAR
Months Days
IF UNDER 24 HRS.
Hours Min. | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | | | | | | | | | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Virginia</u> | | | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME
<u>Oliver W. Catlett</u> | | | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Lucy P. Lake</u> | | | | | | | | | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u> | | | | | | | | | | | | 16. SOCIAL SECURITY NO.
<u>Yes</u> | | | | | | | | | | | | 17. INFORMANT
<u>Mrs. David Mc Kay</u> Address <u>8310 Draper Lane Silver Spring, Maryland</u> | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma Liver</u>
DUE TO <u>Adenocarcinoma Left Breast</u> (b)
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, <u>170X</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>INTERVAL BETWEEN ONSET AND DEATH</u>
<u>3 months</u>
<u>9 months</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | | | | | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | | | | | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | | | | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1967</u> to <u>July 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1967</u> , and that death occurred at <u>5:30 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | | 22a. SIGNATURE
<u>Earl H. Mitchell</u> M.D. | | | | | | | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED
<u>7/5/67</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Earl H. Mitchell</u> | | | | | | | | | | | | 22d. ADDRESS
<u>2029 2 St., NW, Washington, D.C.</u> | | | | | | | | | | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | | | | | | | | | | | 23b. DATE THEREOF
<u>July 8, 1967</u> | | | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery</u> | | | | | | | | | | | | 23d. LOCATION (City, town or county) (State)
<u>Suitland, Maryland</u> | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>Warner E. Humphrey, Inc.</u> | | | | | | | | | | | | 24b. ADDRESS
<u>4434 Georgia Avenue Silver Spring, Md.</u> | | | | | | | | | | | | 25a. REC'D BY REGISTRAR
<u>JUL 7 1967</u> | | | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

124

6770

1910
1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

1910

1910

1910
1911
1912
1913
1914
1915
1916
1917
1918
1919
1920
1921
1922
1923
1924
1925
1926
1927
1928
1929
1930
1931
1932
1933
1934
1935
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952
1953
1954
1955
1956
1957
1958
1959
1960
1961
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
1972
1973
1974
1975
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
1988
1989
1990
1991
1992
1993
1994
1995
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011
2012
2013
2014
2015
2016
2017
2018
2019
2020
2021
2022
2023
2024
2025
2026
2027
2028
2029
2030
2031
2032
2033
2034
2035
2036
2037
2038
2039
2040
2041
2042
2043
2044
2045
2046
2047
2048
2049
2050
2051
2052
2053
2054
2055
2056
2057
2058
2059
2060
2061
2062
2063
2064
2065
2066
2067
2068
2069
2070
2071
2072
2073
2074
2075
2076
2077
2078
2079
2080
2081
2082
2083
2084
2085
2086
2087
2088
2089
2090
2091
2092
2093
2094
2095
2096
2097
2098
2099
2100

16
24 hours after death. Page 4
ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4
TO HOSPITAL: Be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09751

09756

| | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 Lee Ave.</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>
d. STREET ADDRESS <u>111 Lee Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>Effie</u> Middle <u>Columbia</u> Last <u>Green</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>24</u> Year <u>1967</u> | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>11/29/77</u> | | 9. AGE (In years last birthday) <u>89</u> yrs. | | 10. UNDER 1 YEAR Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>nurse</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | | 11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>John F. Williams</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Matvenia Baukley</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>218-54-6466</u> | | 17. INFORMANT <u>Ivy Green</u> | | Address <u>111 Lee Ave. Takoma Park, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Congestive heart failure</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerotic cardiovascular disease</u>
DUE TO (c) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2-3 days</u>
<u>15 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Metastatic intra cranial tumor. (? primary site)</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u> </u> | | | | | | | |
| 20c. TIME OF INJURY
Hour <u> </u> e.m. <u> </u> p.m. <u> </u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> | | 20f. (City or town) <u> </u> | | (County) <u> </u> | | (State) <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 1966</u> to <u>July 24, 1967</u> that (I) (we) last saw the deceased alive on <u>24 July 1967</u> and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>John D. Guswold</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED <u> </u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>John D. Guswold MD</u> | | | | 22d. ADDRESS <u>4830 "V" St N.W. DC.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/27/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u> | | | | 23d. LOCATION (City, town or county) <u>Washington D.C.</u> (State) <u> </u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W.R. Huntman</u> | | | | ADDRESS <u>5125 Georgia Ave N.W. Wash D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE <u> </u> | |
| | | | | DATE <u>JUL 28 1967</u> | | | | | | | |

1958

1958
1958
1958

1958
1958
1958

1958
1958
1958

1958
1958
1958

1958
1958
1958

1958
1958
1958

1958
1958
1958

09752

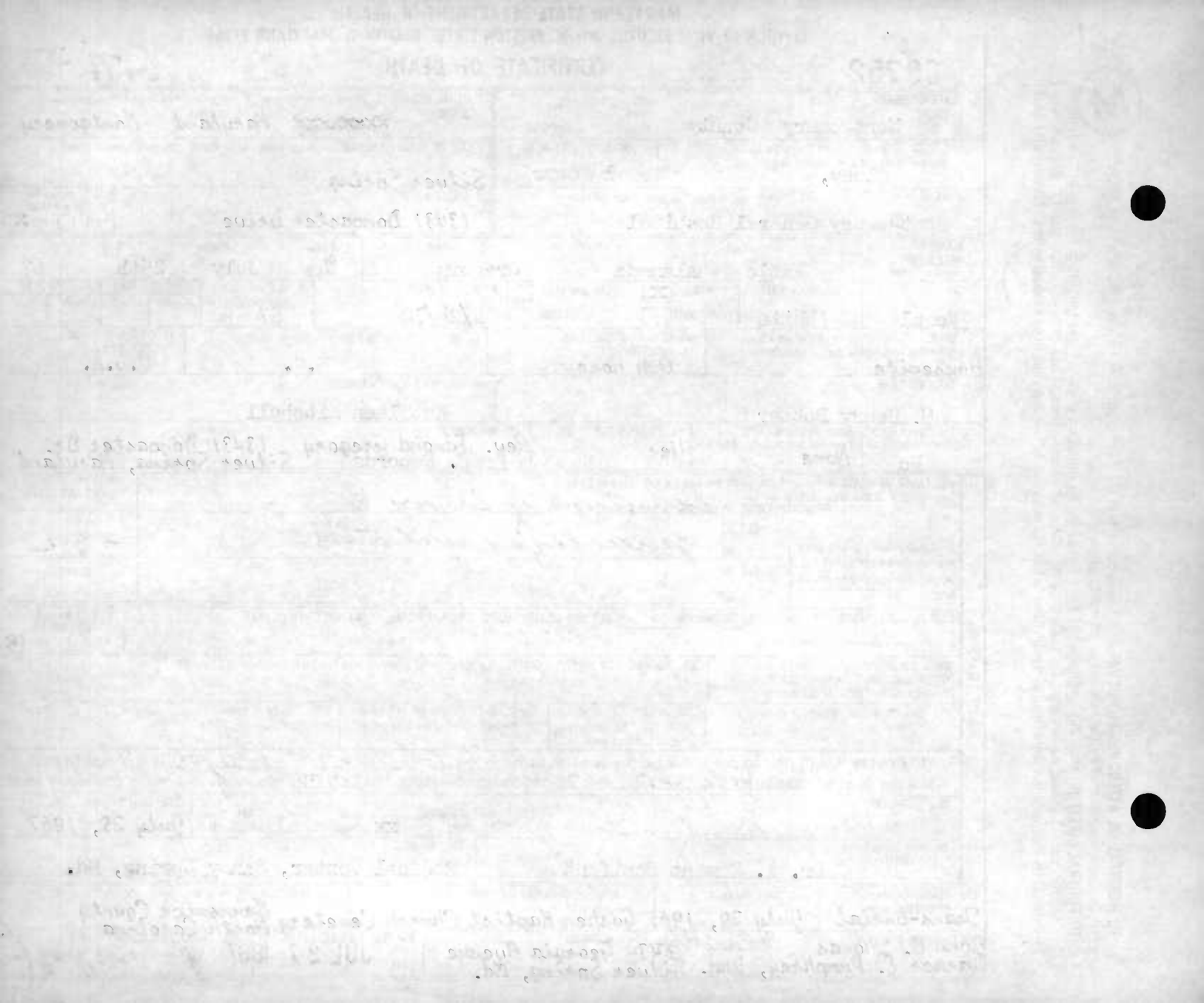
CERTIFICATE OF DEATH

09757

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery County</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Florida <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Olney,</u> | | c. LENGTH OF STAY IN lb
<u>18 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Montgomery General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>Katie Alameda Gregory</u> | | 4. DATE OF DEATH
Month Day Year
<u>July 25th 1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/24/10</u> |
| 9. AGE (In years lost birthday)
<u>57 yrs.</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>J. Henry Potter</u> | | 14. MOTHER'S MAIDEN NAME
<u>Kathleen Mitchell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>Yes</u> | |
| 17. INFORMANT
<u>Rev. Edmond Gregory</u>
<u>Hosp. Records</u> | | Address
<u>13431 Doncaster Dr. Silver Spring, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma of breast</u>
DUE TO (b) <u>generalized metastases</u>
DUE TO (c) <u>2 yr</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | INTERVAL BETWEEN ONSET AND DEATH | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1967</u> , to <u>July 25, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 25, 1967</u> , and that death occurred at <u>2:17 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. A. Dement Bonifant</u> | | 22b. DATE SIGNED
<u>July 25, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Dr. A. Dement Bonifant</u> | | 22d. ADDRESS
<u>Medical Center, Sandy Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Trans-burial</u> | 23b. DATE THEREOF
<u>July 29, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Goshen Baptist Church Cemetery Brunswick County North Carolina</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Georgia Avenue</u> |
| 24. FUNERAL DIRECTOR
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 27 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Yuage</u> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|-------------------------------------|
| 09753 | | 09753 | |
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND
b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA | | c. LENGTH OF STAY IN 1b
BETHESDA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SUBURBAN | | d. STREET ADDRESS
4903 BATTERY LANE | |
| 3. NAME OF DECEASED (Type or print)
First PETER Middle JOHN Last GREGORY | | 4. DATE OF DEATH
Month JULY Day 30 Year 19 67 | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1/9/1890 |
| 9. AGE (In years last birthday)
77 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY
Candy | |
| 11. BIRTHPLACE (County & State, or foreign country)
GREECE | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A | |
| 13. FATHER'S NAME
JOHN GREGORY | | 14. MOTHER'S MAIDEN NAME
AMANDA | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO.
178-23-7944 | |
| 17. INFORMANT
WIFE, ANNA GREGORY (SAME AS ABOVE) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
334X
IMMEDIATE CAUSE (a) Respiratory arrest
DUE TO (b) Cerebral atherosclerotic Bulbar
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) palsy
several years | | INTERVAL BETWEEN ONSET AND DEATH
Immediate | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
General aging processes | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
none | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (his hospital) attended the deceased from Jan 12 , 19 66 , to July 29 , 19 67 , that (I) (we) last saw the deceased alive on July 29 , 19 67 , and that death occurred at 8:45 A M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Allen J. O'Neill | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) ALLEN J. O'NEILL | | 22d. ADDRESS
8601 Old Georgetown Rd Bethesda Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
8-1-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY, Bethesda, Maryland | | 25a. REC'D BY REGISTRAR
AUG 3 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

CENTRAL OF DEATH

0-123

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

WATKINS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09754

Item 4 Film 33917/28/67

CERTIFICATE OF DEATH

09759

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton
c. LENGTH OF STAY IN lb
11 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
University Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring
d. STREET ADDRESS
11711 Lovejoy St.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Lillian Ethel Griffin | | | | 4. DATE OF DEATH
Month Day Year
July 11 19 67 | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12/1/1882 | |
| 9. AGE (In years last birthday)
84 yrs. | | IF UNDER 1 YEAR
Months Days
11 19 | | IF UNDER 24 HRS.
Hours Min.
15 1 | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
At Home | | 11. BIRTHPLACE (County & State, or foreign country)
Louisville, Kentucky | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
? Lightfoot | | | | 14. MOTHER'S MAIDEN NAME (unknown) | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
none | | 17. INFORMANT
11711 Lovejoy Street
Mrs. Dee Wender-Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO as CVD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) as CVD
DUE TO (c) as CVD | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 days
long period | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Pneumonia Carcinoma of the Colon | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input checked="" type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept , 19 67 , to July 11 , 19 67 , that (I) (we) last saw the deceased alive on July 11 , 19 67 , and that death occurred at 7 P.M. from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Russell C. Bufalino | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Russell Bufalino, M.D. | | | | 22d. ADDRESS
1429 University Blvd., West Silver Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
July 15, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
ELMWOOD CEM. | | 23d. LOCATION (City or Town) (County) (State)
Birmingham, Ala. | |
| 24. FUNERAL DIRECTOR
W.W. Chambers Co. | | | | ADDRESS
1400 Chapin St. N.W. Wash. D.C. | | 25a. REC'D BY REGISTRAR
JUL 14 1967 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

STATEMENT OF

DATE

BY

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

DATE

STATEMENT OF

DATE

DATE

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | 33 | 34 | 35 | 36 | 37 | 38 | 39 | 40 | 41 | 42 | 43 | 44 | 45 | 46 | 47 | 48 | 49 | 50 | 51 | 52 | 53 | 54 | 55 | 56 | 57 | 58 | 59 | 60 | 61 | 62 | 63 | 64 | 65 | 66 | 67 | 68 | 69 | 70 | 71 | 72 | 73 | 74 | 75 | 76 | 77 | 78 | 79 | 80 | 81 | 82 | 83 | 84 | 85 | 86 | 87 | 88 | 89 | 90 | 91 | 92 | 93 | 94 | 95 | 96 | 97 | 98 | 99 | 100 | 101 | 102 | 103 | 104 | 105 | 106 | 107 | 108 | 109 | 110 | 111 | 112 | 113 | 114 | 115 | 116 | 117 | 118 | 119 | 120 | 121 | 122 | 123 | 124 | 125 | 126 | 127 | 128 | 129 | 130 | 131 | 132 | 133 | 134 | 135 | 136 | 137 | 138 | 139 | 140 | 141 | 142 | 143 | 144 | 145 | 146 | 147 | 148 | 149 | 150 | 151 | 152 | 153 | 154 | 155 | 156 | 157 | 158 | 159 | 160 | 161 | 162 | 163 | 164 | 165 | 166 | 167 | 168 | 169 | 170 | 171 | 172 | 173 | 174 | 175 | 176 | 177 | 178 | 179 | 180 | 181 | 182 | 183 | 184 | 185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|------|

JUL 14 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09755

09760

| | | | | | | | |
|---|--|--|-------------------------|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE WASH. DC. b. COUNTY S.E. | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
S.E. | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS HOSPITAL | | | | d. STREET ADDRESS
3827 "W" STREET, S.E. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
JOSEPHINE A. GROVE | | | | 4. DATE OF DEATH
Month 7 Day 21 Year 1967 | | | |
| 5. SEX
F | | 6. COLOR OR RACE
W | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
7-26-18 | |
| 9. AGE (In years last birthday)
48 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Asst. Bkkg. | | 10b. KIND OF BUSINESS OR INDUSTRY
Felman Co. | | 11. BIRTHPLACE (County & State, or foreign country)
Penna. | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | | 13. FATHER'S NAME
Harry G. Carter | | | |
| 14. MOTHER'S MAIDEN NAME
Alice Horner | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | | |
| 16. SOCIAL SECURITY NO.
579-01-2991 | | | | 17. INFORMANT
Joseph R. Haney - Same as #2 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkin's Disease
201X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
5 yrs. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/21 , 19 65 , to 7/21 , 19 67 , that (I) (we) lost saw the deceased alive on 7/21 , 19 67 , and that death occurred at 3 P. M, from causes on and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
G. Leonard Good | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
7/22/67 | |
| 22c. PHYSICIAN'S NAME (Type)
G. Leonard Good | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/25/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl. Cem. | | 23d. LOCATION (City or Town) (County) (State)
Fort Myer Virginia | |
| 24. FUNERAL DIRECTOR
E. W. Foster - Lee Funeral Home | | | | 25a. REC'D BY REGISTRAR
DATE JUL 25 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

MEDICAL CERTIFICATION

2541 JCSA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|---|--|---|-------------------------|--|--|---|--|---|--|---|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 09756 | | | | | CERTIFICATE OF DEATH | | | | | 09761 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Hyattsville</u> 16.2 | | | d. STREET ADDRESS
<u>4422 68th Place</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | | | | d. STREET ADDRESS | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print) First <u>—</u> Middle <u>—</u> Last <u>Haack</u> | | | | | 4. DATE OF DEATH Month <u>July</u> Day <u>22</u> Year <u>1967</u> | | | | | | | | | |
| 5. SEX
<u>male</u> | | 6. COLOR OR RACE
<u>white</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>July 22 1907</u> | | 9. AGE (In years last birthday) yrs. <u>3</u> Min. <u>—</u> | | IF UNDER 1 YEAR
Months <u>—</u> Days <u>—</u> | | IF UNDER 24 HRS.
Hours <u>3</u> Min. <u>—</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland-Montgomery</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | |
| 13. FATHER'S NAME
<u>Russell F. Haack</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>Beverly Ann Bucher</u> | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Father</u> | | | | Address
<u>as above</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>776X Prematurity</u>
DUE TO (b) <u>—</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (c) <u>—</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>—</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 22, 1967</u> to <u>July 22, 1967</u> that (I) (two) saw the deceased alive on <u>July 22, 1967</u> , and that death occurred at <u>4:20 PM</u> , from causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE <u>Roberto Casas</u> | | | | M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED
<u>7.24-67</u> | | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Roberto Casas, M.D.</u> | | | | 22d. ADDRESS
<u>1105 SPRING ST., SILVER SPRING, MD.</u> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/27/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of "Heaven Cemetery"</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring Montg. Md.</u> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home</u> | | | | 10055 Rockville Pike
<u>Rockville, Md.</u> | | DATE <u>JUL 31 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>James Judge</u> | | | | | | |

Page 12 of 12

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

CERTIFICATE OF DEATH

09762

| | | | |
|---|---------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>734 Carr Ave</u> | | d. STREET ADDRESS <u>734 Carr Ave</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Gladys</u> First <u>Haller</u> Middle <u>S</u> Last | | 4. DATE OF DEATH <u>July 28</u> 19 <u>67</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-14-10</u> 9. AGE (In years last birthday) <u>57</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleslady</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>dress shop</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>John Shultz Wm. Shultz</u> | | 14. MOTHER'S MAIDEN NAME <u>FLORENCE PEPPER</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>187-16-4802</u> | |
| 17. INFORMANT <u>Husband -</u> Address <u>734 Carr Ave, Rockville Md</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>4 1/2 month</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Jan 17</u> , 19 <u>67</u> to <u>July 28</u> , 19 <u>67</u> , that (I) (<u>not</u>) last saw the deceased alive on <u>July 20</u> , 19 <u>67</u> , and that death occurred at <u>12:55 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Stephen C. Cromwell</u> | | 22b. DATE SIGNED <u>7-28-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/31/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Monocacy</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Beallsville Montg. Md</u> | |
| 24. FUNERAL DIRECTOR <u>Hilton Funeral Home Barnesville Md</u> | | 25a. REC'D BY REGISTRAR <u>AUG 1 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|--|---|---|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 09758 | | | |
| 09763 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
c. LENGTH OF STAY IN 1b
3 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium and Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville
d. STREET ADDRESS
7401 New Hampshire avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Andrew Jackson Harrison | | 4. DATE OF DEATH
Month July Day 26 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8-25-92 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Chief of Procurement Veterans Admin. | | 10b. KIND OF BUSINESS OR INDUSTRY
Maryland | 12. CITIZEN OF WHAT COUNTRY?
America |
| 13. FATHER'S NAME
Andrew Jackson Harrison | | 14. MOTHER'S MAIDEN NAME
Rose Eagan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
Yes U.S. Army WWI | | 16. SOCIAL SECURITY NO.
216-46-0108 | 17. INFORMANT
MARY K. HARRISON
Patient's chart
Address SAME AS #2 |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 7861
DUE TO Uremia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Chronic urinary retention
DUE TO
(c) 6 months | | | INTERVAL BETWEEN ONSET AND DEATH
6 months |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Uremia
Anticoagulant heart disease | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7-10- , 1967, to 7-26 , 1967, that (I) (we) last saw the deceased alive on 7-26 , 1967, and that death occurred at 4:10 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Seruch T. Kimble | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
7-27-67 |
| 22c. PHYSICIAN'S NAME (Type)
Seruch T. Kimble | | 22d. ADDRESS
927 Pershing Dr., Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
July 31, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
New Cathedral Cemetery | 23d. LOCATION (City or Town) (County) (State)
Baltimore Maryland |
| 24. FUNERAL DIRECTOR
John B. Warner E. Pumphrey, Inc. | | 25a. REC'D BY REGISTRAR
AUG 1 1967 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1903
REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1899

1903



CERTIFICATE OF DEATH

09759

09764

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Mount Airy</u> | |
| c. LENGTH OF STAY IN lb
<u>DOA</u> | | d. STREET ADDRESS
<u>Route #3</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Jerry</u> Middle <u>Wayne</u> Last <u>Hartman</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>29</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>22 December 1958</u> |
| 9. AGE (In years lost birthday)
<u>8</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>--</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Harvey E. Hartman</u> | | 14. MOTHER'S MAIDEN NAME
<u>Shirley L. Mullinix</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO.
<u>None</u> | |
| 17. INFORMANT
<u>The Medical Records</u> | | 18. ADDRESS
<u>The Clinical Center, Bethesda, Maryland</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Lymphatic Leukemia</u>
2043 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u> </u>
(c) <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (A) (this hospital) attended the deceased from (DOA) <u>29 July 1967</u> to <u>29 July 1967</u> that (X) (we) last saw the deceased alive on (DOA) <u>29 July 1967</u> , and that death occurred at <u>3:30 M.</u> from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Dr. Robert C. Young</u> | | 22b. DATE SIGNED
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>29 July 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Robert C. Young, M.D.</u> | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>July 31, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Poplar Springs Meth.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Poplar Springs, Md.</u> |
| 24. FUNERAL DIRECTOR
ADDRESS
<u>Olin L. Molesworth, Damascus, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AUG 1 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jager</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DECLARATION OF INDEPENDENCE

1776

John Adams

July 4, 1776
The Continental Congress
Philadelphia, Pennsylvania

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|---------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 09760 | | | |
| CERTIFICATE OF DEATH | | | |
| 09765 | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg
c. LENGTH OF STAY IN 1b
30.4 | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/>
a. STATE Maryland
b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Baltimore
d. STREET ADDRESS
4500 Hampnett Avenue
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Blanche Middle Simonds Last Henry | | 4. DATE OF DEATH
Month July Day 19 Year 1967 | |
| 5. SEX F | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH
June 30, 1885 |
| 9. AGE (In years lost birthday)
82 yrs. | | 10. IF UNDER 1 YEAR
Months 19 Days 19 Hours 19 Min. 19 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
housewife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Baltimore, Md. | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Curtis Bennett Simonds | | 14. MOTHER'S MAIDEN NAME
Katherine Ohlgart | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
215-54-8925 JL | |
| 17. INFORMANT
Asbury Methodist Home, Gaithersburg, Md. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1538 IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage (Colon)
DUE TO (b) Carcinoma of colon
DUE TO (c) Carcinoma of colon
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour 19 o.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/28/63 , 19__, to 7/19/67 , 19__, that (I) (we) last saw the deceased alive on 7/19/67 , 19__, and that death occurred at 5:30 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Henry C. Scruggs, M.D. | | 22b. DATE SIGNED
7/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Henry C. Scruggs, M. D. | | 22d. ADDRESS
5413 Cedar Lane Bethesda Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE THEREOF
7/20/67. | |
| 23c. NAME OF CEMETERY OR CREMATORY
Greenmount Crematory | | 23d. LOCATION (City or Town) (County) (State)
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
Leonard J. Ruck, Inc. Balto, Md. 21214 | | 25a. REC'D BY REGISTRAR
JUL 21 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Richard Judge | | | |

OFFICE OF THE ATTORNEY GENERAL

Maryland

Montgomery

Baltimore

Baltimore

about Methodist Lane for the Agent, Inc.

1500 Hampshire Avenue
July 19 1885

June 30, 1885

Baltimore, Md.

Charles Bennett & Son

215-A-325 41 Agency Methodist Lane, Baltimore, Md.

Henry O. Bennett, Jr.

Baltimore, Md.

July 21 1885

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|---------------------------|--|--|
| 09761 | | 09766 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>D.C.</u>
b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> 47-3 | |
| c. LENGTH OF STAY IN 1b <u>1 day</u> | | d. STREET ADDRESS <u>133 Webster St N.W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Lillian C. Henry</u>
First Middle Last | | 4. DATE OF DEATH <u>7</u> Month <u>5</u> Day <u>19</u> Year <u>67</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-8-1904</u> 63 yrs. |
| 9. AGE (In years last birthday) <u>63</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Checker</u> | |
| 10b. KIND OF BUSINESS OR INDUSTRY <u>Safeway Store</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Utica M.D.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | | 13. FATHER'S NAME <u>Clem Brasley</u> | |
| 14. MOTHER'S MAIDEN NAME <u>same as</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u> | |
| 16. SOCIAL SECURITY NO. <u>579 32 3077</u> | | 17. INFORMANT <u>Mr. Russell Henry above</u> Address <u>same as</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>ACUTE CONGESTIVE FAILURE</u>
5271 DUE TO
(b) <u>EMPHYSEMA</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO
(c) | | INTERVAL BETWEEN ONSET AND DEATH <u>36 Hrs</u>
<u>10 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>67</u> , to <u>JULY</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>JULY 7</u> 19 <u>67</u> and that death occurred at <u>9:50</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>[Signature]</u> | | 22b. DATE SIGNED <u>7/5/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>DR LEO F. DOMINIAN</u> | | 22d. ADDRESS <u>8218 WISCONSIN AVE BETHESDA</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>July 8, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Olivet Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Frederick, Maryland</u> | |
| 24. FUNERAL DIRECTOR <u>Donald M. Etchison & Son, Frederick, Maryland</u> | | 25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |
| DATE <u>JUL 10 1967</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

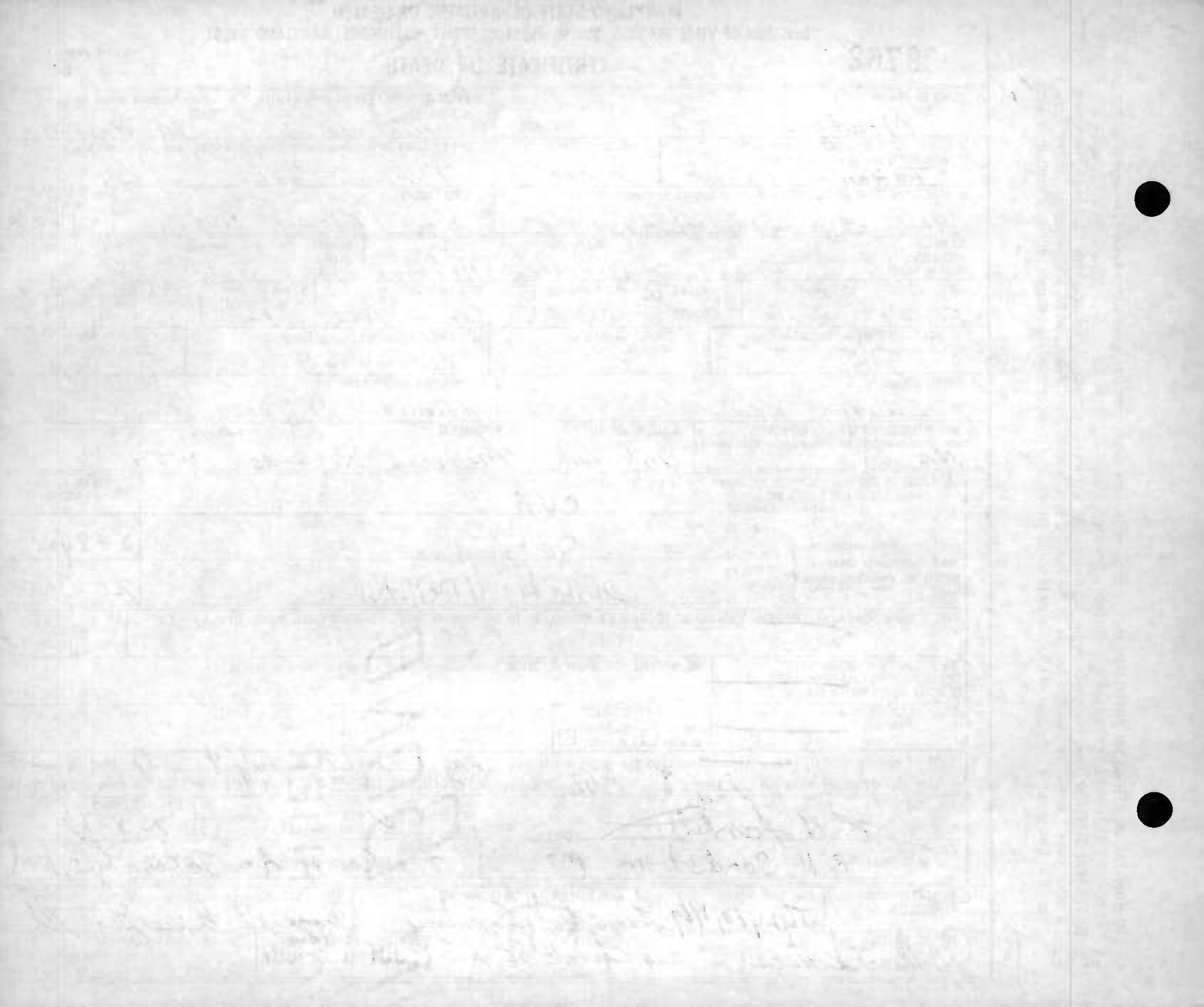
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|----------------------------------|---|---|
| 09762 | | 09767 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u> 151 | |
| c. LENGTH OF STAY IN 1b
<u>6 hours</u> | | d. STREET ADDRESS
<u>7411 Flower Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium & Hosp.</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
<u>Thekla Dorothea Herwick</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>8</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Jan. 2, 1885</u> |
| 9. AGE (In years lost birthday)
<u>82 yrs.</u> | | IF UNDER 1 YEAR
Months <u>8</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Norway</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Edward Rowe</u> | | 14. MOTHER'S MAIDEN NAME
<u>Amelia Ryberg</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO
<u>Unknown</u> | |
| 17. INFORMANT
<u>Medical Records WSH</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CVA</u>
DUE TO (b) <u>CHF.</u>
DUE TO (c) <u>Diabetes Mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2-3 yrs</u>
<u>20-30 yrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 1, 1967</u> to <u>July 8, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 8, 1967</u> , and that death occurred at <u>4:25 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>R. N. Sandstrom</u> | | 22b. DATE SIGNED
<u>7-8-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>R. N. Sandstrom MD</u> | | 22d. ADDRESS
<u>7701 Carroll Ave Takoma Park, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>July 10, 1967</u> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Trinity Lutheran Cemetery</u> | | 23d. LOCATION (City or town) (County) (State)
<u>Pigeon Bl. Prince Georges Co. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Arthur Walters</u> | | 25a. REC'D BY REGISTRAR
<u>254 Carroll St. - RG</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>James J. Jones</u> | | DATE
<u>JUL 11 1967</u> | |



09763

CERTIFICATE OF DEATH

09768

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Sudden death cleared with Medical Examiner Dr. John Hall.

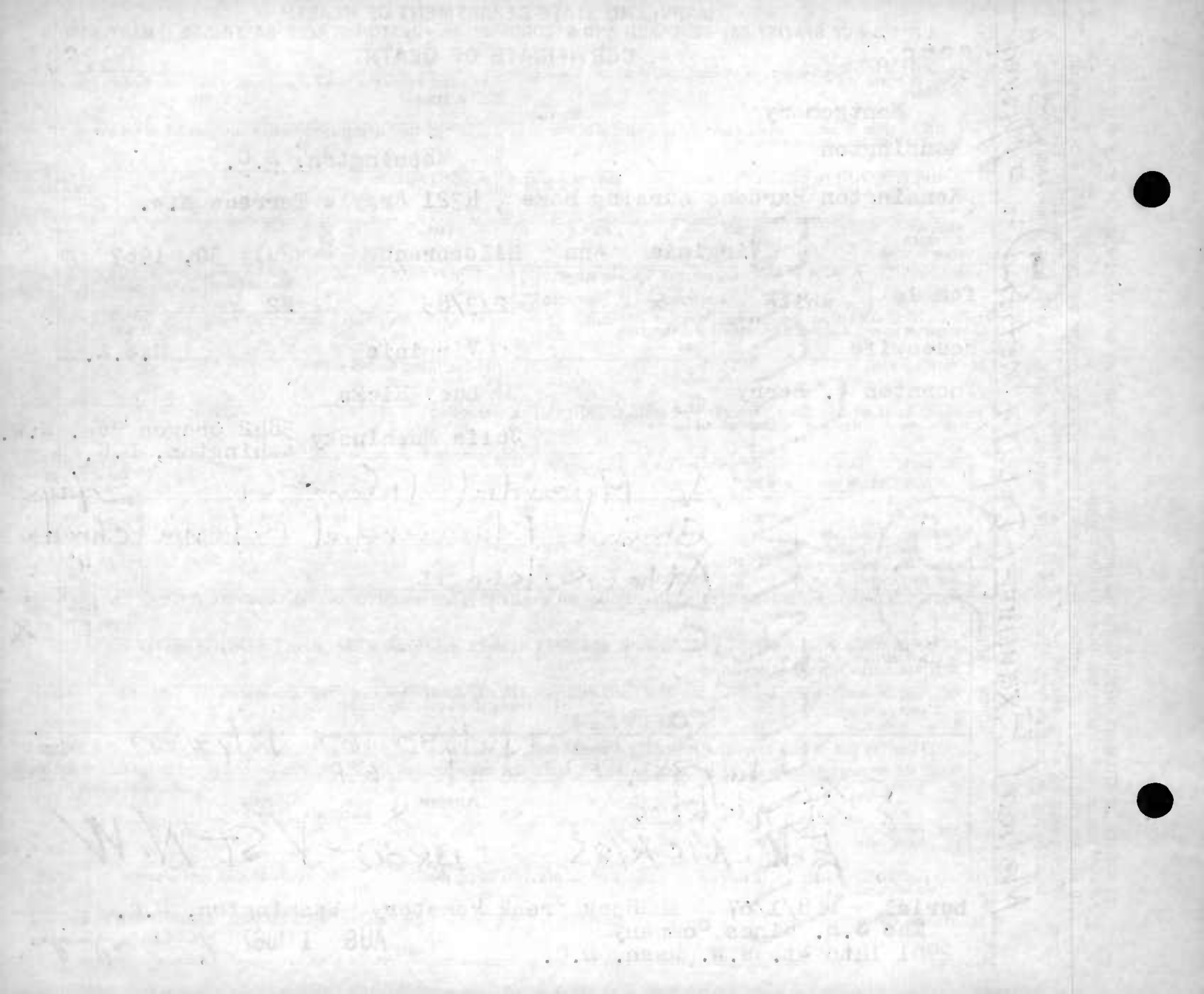
| | | | |
|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. LENGTH OF STAY IN 1b
<u>1511</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>19 Argyle Street</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>KATE HYATT HIGGINS</u> | | 4. DATE OF DEATH Month Day Year
<u>July 27, 1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 21, 1894</u> |
| 9. AGE (In years last birthday) yrs.
<u>72</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>N. Carolina</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 13. FATHER'S NAME
<u>James L. Hyatt</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Margaret Griffith</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address
<u>Clara Lee Hyatt-Item # 2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u>
<u>260X</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Arteriosclerosis</u> DUE TO
(c) <u>Severe diabetes mellitus</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hours</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>July 27, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 27, 1967</u> , and that death occurred at <u>1:30 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Corinne Cooper</u> | | 22b. DATE SIGNED
<u>7/27/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Corinne Cooper</u> | | 22d. ADDRESS
<u>104 S. Washington St., Rockville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Bur-Transit</u> | 23b. DATE THEREOF
<u>7/29/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gaston Memorial Park</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Gastonia, N. Carolina</u> |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home-1331 Rockville Pike</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 31 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Jones</u> | | 25c. REGISTRAR'S SIGNATURE
<u>J. Charles Jones</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner (Deputy) notified & approved

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
|---|--|---------------------------|---|---|--|---|--|--|--|
| 09764 | | | | | 09769 | | | | |
| 1. PLACE OF DEATH | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) | | | | |
| a. COUNTY
Montgomery MARYLAND | | | | | a. STATE
b. COUNTY | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Kensington | | | | c. LENGTH OF STAY IN 1b | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Washington, D.C. | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
Kensington Gardens Nursing Home | | | | | d. STREET ADDRESS
4321 Argyle Terrace N.W. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First
Virginia | | Middle
Ann | | Last
Hildebrand | | 4. DATE OF DEATH
Month
July
Day
30
Year
1967 | |
| 5. SEX
female | | 6. COLOR OR RACE
white | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
2/3/85 | | 9. AGE (In years last birthday)
82 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Thornton F. Berry | | | | | 14. MOTHER'S MAIDEN NAME
Lucy Hicks | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT
Address
Julia Mushinsky, 5842 Oregon Ave. N.W. Washington, D.C. | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Ac. Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Myocardial ischemic
(c) Atherosclerosis
INTERVAL BETWEEN ONSET AND DEATH
2 days
chronic
4
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m.
19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | |
| 21. I certify that (I) (this hospital) attended the deceased from July 30, 1967 to July 31, 1967, that (I) saw the deceased alive on July 28, 1967, and that death occurred at 6:30 PM, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
E. W. Nicklas | | | | | 22b. DATE SIGNED | | | | |
| 22c. PHYSICIAN'S NAME (Type)
E. W. Nicklas | | | | | 22d. ADDRESS
4830 - 1st St N.W. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | | 23b. DATE THEREOF
8/1/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Rock Creek Cemetery | | 23d. LOCATION (City, town or county) (State)
Washington, D.C. | | |
| 24. FUNERAL DIRECTOR
The S.H. Hines Company
2901 14th St. N.W. Wash. D.C. | | | | | 25a. REC'D BY REGISTRAR
AUG 1 1967
25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | |



FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

| <div> <div>7 1</div> <div>Items 18&21 Film 390 7-1</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>09765</div> <div>09770</div> </div> | | | | | | | | | |
|--|--|---|-------------------------|--|---|--|--|---|---|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | | 16-20 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash San + Hospital</u> | | | | | d. STREET ADDRESS <u>813 Colby Ave.</u> | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Martha J. Hill</u> | | | | | 4. DATE OF DEATH <u>7</u> Month <u>4</u> Day <u>19</u> Year <u>67</u> | | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>negro</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>94</u> | | 9. AGE (In years last birthday) yrs. <u>94</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> | | 11. BIRTHPLACE (State or foreign country) <u>Washington, DC.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Isaac Baker</u> | | | | | 14. MOTHER'S MAIDEN NAME <u>Lucy Washington</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>218-56-3402</u> | | 17. INFORMANT <u>Hattie Thurston</u> Address <u>Takoma Park, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Partial Malnutrition</u>
4221 DUE TO
(b) <u>Cardiovascular disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c) <u>Generalized arterio Sclerosis</u> | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Weeks</u>
<u>Years</u>
<u>Years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <u>John B. Bell</u> M.D. | | | | | 22. DATE SIGNED <u>7/4/67</u> | | | | |
| EXAMINER'S NAME (Type) | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7--8-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Harmony Memorial Park</u> | | | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Md.</u> | | |
| 24. FUNERAL DIRECTOR <u>John T. Rhines Co</u> ADDRESS <u>3015 12th St., N.E., Wash., D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>UL 7</u> DATE <u>7/4/67</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

Personal Home
 John T. Williams
 7-4-07
 Personal Home
 3-18-08
 Personal Home
 3-18-08
 Personal Home
 3-18-08

CERTIFICATE OF DEATH

09766

09771

| | | | |
|---|---------------------------|---|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>MARYLAND</i> b. COUNTY <i>Montgomery</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i> | | c. LENGTH OF STAY IN lb <i>D.O.A.</i> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban</i> | | d. STREET ADDRESS <i>214 N VAN Buren St</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>HELMUTH Max</i> | | 4. DATE OF DEATH
Month <i>July</i> Day <i>9</i> Year <i>1967</i> | |
| 5. SEX <i>m</i> | 6. COLOR OR RACE <i>w</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>Dec. 29, 1907</i> |
| 9. AGE (In years birth day) <i>67</i> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Supt. Police Const. Co.</i> | |
| 11. BIRTHPLACE (County & State, or foreign country) <i>Germany</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Unknown</i> | | 14. MOTHER'S MAIDEN NAME <i>Anna (Unknown)</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <i>Wife - Nell - Same</i> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>
DUE TO (b) <i>ASHD</i>
DUE TO (c) <i>4201</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH <i>12 hours</i>
<i>4 years</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <i>19</i> o.m. p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>November, 1964</i> , to <i>July 9, 1967</i> , that (I) (we) last saw the deceased alive on <i>July 8, 1967</i> , and that death occurred at <i>12:11 A.M.</i> from causes and on the date stated above | | | |
| 22a. SIGNATURE <i>Robert C. Macon</i> | | 22b. DATE SIGNED <i>7-9-67</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>Robert C. Macon</i> | | 22d. ADDRESS <i>809 Viers Mill Rd., Rockville, Maryland</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>7-11-67</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY <i>Parklawn Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State) <i>Rockville, Maryland</i> | |
| 24. FUNERAL DIRECTOR <i>ROBERT T. A. PUMPHREY, Bethesda, Maryland</i> | | 25a. REC'D BY REGISTRAR <i>JUL 13 1967</i> | |
| 25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, within any event, within 72 hours after death.

1950

1950

1950

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CORNER "CLEARED" THE CASE

09767

09772

Item 3 Film 6520 7/14/67

| | | | | | | | | | | | |
|---|--|-------------------------------|--|--|--|---|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>NEW JERSEY</u> b. COUNTY <u>BERGEN</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | | | c. LENGTH OF STAY IN 1b <u>2 WEEKS</u> | | | | | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FORT LEE</u> | | | | | | 67.3 | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1710 FLORA LANE</u> | | | | | | d. STREET ADDRESS <u>HORIZON HOUSE 3</u> | | | | | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>THORBJORG MARIA HOLM-ANDERSON</u> | | | | | | 4. DATE OF DEATH Month Day Year <u>JULY 2 1967</u> | | | | | |
| 5. SEX <u>FEMALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>JUNE 1, 1911</u> | | 9. AGE (In years lost birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>ICELAND</u> | | | |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | | | 13. FATHER'S NAME <u>GISLASON, INGOLFUR</u> | | | | 14. MOTHER'S MAIDEN NAME <u>VIGFUSDOTTIR, ODDNY</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>131-382525</u> | | | | 17. INFORMANT Address <u>MRS. THORS, AGUSTA 1710 FLORA LANE SILVER SPRING, MD.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE HEART FAILURE</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> | |
| 4214 DUE TO (b) <u>CHRONIC MYOCARDIAL DISEASE AND FAILURE</u> | | | | | | | | | | SEVERAL YEARS | |
| Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (c) <u>CHRONIC VALVULAR HEART DISEASE</u> | | | | | | | | | | SEVERAL YEARS | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (11) (this hospital) attended the deceased from <u>6/19</u> 19 <u>67</u> to <u>JULY 2</u> 19 <u>67</u> , that (11) (we) last saw the deceased alive on <u>JULY 2</u> 19 <u>67</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>James A. Roberts</u> M.D. | | | | | | 22b. DATE SIGNED <u>JULY 2, 1967</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES A. ROBERTS</u> | | | | | | 22d. ADDRESS <u>8907 GEO. AVE. SILVER SPRING, MARYLAND</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | | | 23b. DATE THEREOF <u>7/6/1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City, town, or county) (State) <u>Rockville Centre, New York</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> | | | | | | 25a. REC'D BY REGISTRAR <u>EUL 5</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

09768

CERTIFICATE OF DEATH

09778

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
KENSINGTON
c. LENGTH OF STAY IN 1b
11506 Lund Place, Kensington, Md.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
11506 Lund Place, Kensington, Md. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 151
11506 Lund Place, Kensington, Md.
d. STREET ADDRESS
Kensington, Md.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
CLARA MAE HOPKINS
First Middle Last | | 4. DATE OF DEATH
July 13 1967
Month Day Year | |
| 5. SEX
Female | 6. COLOR OR RACE
white | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 21, 1936
9. AGE (In years last birthday) yrs. 31 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | 11. BIRTHPLACE (County & State, or foreign country)
Missouri |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 13. FATHER'S NAME
CARL T. CURTIS | |
| 14. MOTHER'S MAIDEN NAME
LOIS WILIE-ATWATER | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No none | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT
11506 Lund Place, James A. Hopkins Kensington, Md.
Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis
DUE TO Hypertensive Hemorrhage
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Prob. Uremia from Nephrotic Syndrome
DUE TO (c) Diabetes Mellitus | | | INTERVAL BETWEEN ONSET AND DEATH
5 months
5 months
21 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7 Sept 1967 , to 13 July 1967 , that (I) (we) last saw the deceased alive on 13 July 1967 , and that death occurred at 11:30 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ann M. Dimitroff | | 22b. DATE SIGNED
7/14/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Ann M. Dimitroff M.D. | | 22d. ADDRESS
11300 Woodson Ave., Kensington, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
July 17, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Minden City Cem. | 23d. LOCATION (City or Town) (County) (State)
Minden, Nebraska |
| 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY BETHESDA, MARYLAND | | 25a. REC'D BY REGISTRAR
JUL 19 1967
25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF CLAIM

2176

MAINTENANCE

MAINTENANCE

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

2176

09769

09774

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Roanoke</u> | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS <u>2918 Rosalind Ave S.W.</u> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Hugh</u> First <u>Oliver</u> Middle <u>Horton</u> Last | | 4. DATE OF DEATH <u>July</u> Month <u>3</u> Day <u>1967</u> Year | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-19-1887</u> |
| 9. AGE (In years last birthday) <u>79</u> | | 10. UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS. Months <u>3</u> Days <u>3</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Director of Parks (Retired)</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Silver Creek Kentucky, USA</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | |
| 13. FATHER'S NAME <u>Thomas Horton</u> | | 14. MOTHER'S MAIDEN NAME <u>Melinda Woodward</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>226-01-3044</u> | |
| 17. INFORMANT <u>Wife</u> <u>HORTON, (Wife)</u> Address <u>2918 Rosalind Ave S.W. Roanoke, Va</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis with</u>
DUE TO (b) <u>massive myocardial infarction sudden</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u></u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>History of Angina - 6 yrs</u> <u>Paralysis</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 2, 1967</u> to <u>July 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 3, 1967</u> , and that death occurred at <u>5:04 A.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Philip E. Jones</u> M.D. | | 22b. DATE SIGNED <u>7/3/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Philip E. Jones</u> | | 22d. ADDRESS <u>500 Pershing Drive Silver Spring Md</u> | |
| 23a. BURIAL-CREMA-TION REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>July 6-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cemetery</u> | 23d. LOCATION (City or town) (County) (State) <u>Roanoke - Va.</u> |
| 24. FUNERAL DIRECTOR <u>L. Arthur Walters</u> | | 25a. RECEIVED BY REGISTRAR <u>254 Carroll St N.W. Washington DC</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | DATE <u>JUL 5 1967</u> | |

2011-2012

Dear Mr. ...

FD 302-10-7

1892

ملفوظات امیر کبیر

10-11-1968

100

10. The first of these is the fact that the

Chas. H. H. H.

09770

CERTIFICATE OF DEATH

09775

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>P.G.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Wheaton</u> | | c. LENGTH OF STAY IN lb
<u>1 1/2 mos.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Capitol Heights</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>University Nursing Home</u> | | | | d. STREET ADDRESS
<u>6402 A Street</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>MARY Virginia Barrett Hough</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>31</u> Year <u>19 67</u> | | | |
| 5. SEX
<u>Fe.</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Nov. 20, 1871</u> | 9. AGE (In years last birthday) <u>95</u> yrs. | IF UNDER 1 Year
Months <u>31</u> Days <u>19</u> Hours <u>67</u> Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Loudoun County, Va.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>James Wilson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Barrett</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>579-28-3297</u> | | 17. INFORMANT
<u>Mrs. Georgie Holden</u> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-</u>
DUE TO (b) <u>Vascular Dementia</u>
DUE TO (c) <u>15 years</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/18</u> , 19 <u>49</u> to <u>7/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> , 19 <u>67</u> , and that death occurred at <u>11:30</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>William Brainin</u> | | | | 22b. DATE SIGNED
<u>7/1/67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>WM BRAININ</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>Aug. 3, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Union Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Leesburg, Loudoun Virginia</u> | |
| 24. FUNERAL DIRECTOR
<u>Francis H. Barber</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>AUG 2 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Francis H. Barber</u> | |

10
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09771

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

09776

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|--|--|---|--|--|--|--|--|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown. Rural
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Montg.
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Germantown.
d. STREET ADDRESS Rural. Rt 1
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
Joseph Green Howes | | 4. DATE OF DEATH
Month July Day 4th Year 1967 | | 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Nov 15th 1880 | | 9. AGE (In years last birthday) 86 yrs | | IF UNDER 1 YEAR
Months 15 Days 1 | | IF UNDER 24 HRS.
Hours 15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer | | | | 10b. KIND OF BUSINESS OR INDUSTRY Farming | | | | 11. BIRTHPLACE (County & State, or foreign country) Montg, Co. Md. | | | | 12. CITIZEN OF WHAT COUNTRY? U S A | | | | | |
| 13. FATHER'S NAME
James R. Howes | | | | | | 14. MOTHER'S MAIDEN NAME
Eliza Green | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. | | | | | | 17. INFORMANT
J. Dorsey Howes . As No 2- | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Carcinoma of prostate
177X DUE TO (b) Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 years
15 years | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | 20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/20 , 19 56 to 7/4 , 19 67 , that (I) (no) last saw the deceased alive on 7/3 , 19 67 , and that death occurred at 10 M, from the causes and on the date stated above. | | | | | | | | | | | | | | | | | |
| 22a. SIGNATURE
James B. Kerk | | | | | | | | 22b. DATE SIGNED
7/5/67 | | | | 22c. PHYSICIAN'S NAME (Type)
DAMASCUS, MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | 23b. DATE THEREOF
7-6-67 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Neelsville Presbyterian | | | | 23d. LOCATION (City, town or county) (State)
Germantown. Md. | | | | | |
| 24 FUNERAL DIRECTOR'S SIGNATURE
Ernest C. Gartner | | | | | | | | 25a. REC'D BY REGISTRAR
JUL 10 1967 | | | | 25b. REGISTRAR'S SIGNATURE
Charles J. J... | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09772

CERTIFICATE OF DEATH

09777

| | | | |
|--|------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING
c. LENGTH OF STAY IN 1b
3 Mo. 7 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
FAIRLAND NURSING HOME | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
D.C. 20007
b. COUNTY
WASH.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47.3
d. STREET ADDRESS
2406 19th ST N.W.
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
RUTH B. HUMMEL
First Middle Last | | 4. DATE OF DEATH
7 17 1967
Month Day Year | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4-28-88
9. AGE (In years last birthday)
79
IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
-o- | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
DAYTON OHIO | | 12. CITIZEN OF WHAT COUNTRY?
US | |
| 13. FATHER'S NAME
LEWIS BOOK WALTER | | 14. MOTHER'S MAIDEN NAME
ANNA GUITNER | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
218-34-7134B | |
| 17. INFORMANT
Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO 332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Cerebral arteriosclerosis with
DUE TO Chronic brain syndrome
(c) 2 years | | INTERVAL BETWEEN ONSET AND DEATH
34 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Arteriosclerotic heart disease | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July 1, 1965 to 17 July, 1967 , that (I) (we) lost saw the deceased alive on 17 July 1967 , and that death occurred at 8:59 M , from causes and on the date stated above | | | |
| 22a. SIGNATURE
William Harvey M.D. | | 22b. DATE SIGNED
17 July 67 | |
| 22c. PHYSICIAN'S NAME (Type)
William Harvey | | 22d. ADDRESS
2121 Penn Ave NW Wash DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-20-67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | |
| 24. FUNERAL DIRECTOR
Lee Funeral Home 300 4th St. NE Wash., D.C. | | 25a. REC'D BY REGISTRAR
20 JUL 20 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

09773

CERTIFICATE OF DEATH

09778

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
1220 Blair Mill Road | | d. STREET ADDRESS
1220 Blair Mill Road | |
| 3. NAME OF DECEASED
(Type or print) First ALBERT Middle Last HYATT | | 4. DATE OF DEATH
Month July Day 31 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
4/23/14 |
| 9. AGE (In years last birthday)
53 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Manufacture Rep | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Russia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Norman Hyatt | | 14. MOTHER'S MAIDEN NAME
Rose Krasner | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
168-07-2705 | |
| 17. INFORMANT
Ronald Hyatt, Son, (See 2 above) | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO (b) Acute
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Acute
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Resection of esophageal diverticulum | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II or item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/25 , 19 67 , to 7/31 , 19 67 , that (I) (we) lost saw the deceased alive on 7/25 , 19 67 , and that death occurred at 3 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Herbert Wechske M.D. | | 22b. DATE SIGNED
8/1/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Herbert Wechske | | 22d. ADDRESS
1800 E. St NW Wash | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
8/2/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Beth Israel Cem. | | 23d. LOCATION (City or Town) (County) (State)
Washington, Pa. | |
| 24. FUNERAL DIRECTOR
Goldberg Funeral Home - 4217 9th Street N.W. | | 25a. REC'D BY REGISTRAR
DATE AUG 4 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

CERTIFICATE OF DEATH

18

| | | | | | | | | | | | |
|------------------------|--|----------------------|--|------------------------|--|----------------------|--|-----------------------|--|----------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | |
| | | | | | | | | | | | |
| Cause of Death | | Disease | | Injury | | Poison | | Other | | | |
| | | | | | | | | | | | |
| Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | | Signature of Deceased | | | |
| | | | | | | | | | | | |

Death registered on 1/21/18

Signature of Registrar

| | | | | | | | | | | | |
|------------------------|--|----------------------|--|------------------------|--|----------------------|--|-----------------------|--|----------------|--|
| Name of Deceased | | Age | | Sex | | Race | | Date of Death | | Place of Death | |
| | | | | | | | | | | | |
| Cause of Death | | Disease | | Injury | | Poison | | Other | | | |
| | | | | | | | | | | | |
| Signature of Physician | | Signature of Coroner | | Signature of Registrar | | Signature of Witness | | Signature of Deceased | | | |
| | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|---|---|--|--|--|--|---|--|
| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <i>Montgomery</i> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <i>MD</i> b. COUNTY <i>Mont</i> | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<i>Silver Spring</i> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<i>2112 Dexter Court</i> | | | | | d. STREET ADDRESS
<i>2112 Dexter Court</i> | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <i>FLORENCE</i> Middle <i>EMILY</i> Last <i>INSCOE</i> | | 4. DATE OF DEATH
Month <i>July</i> Day <i>15</i> Year <i>1967</i> | | 5. SEX
<i>Female</i> | | 6. COLOR OR RACE
<i>White</i> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 8. DATE OF BIRTH
<i>Feb. 15, 1903</i> | | 9. AGE (in years last birthday) <i>64</i> yrs. | | IF UNDER 1 YEAR
Months <i>6</i> Days <i>15</i> | | IF UNDER 24 HRS.
Hours <i>15</i> Min. <i>67</i> | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Homemaker</i> | | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>at home</i> | | 11. BIRTHPLACE (County & State, or foreign country)
<i>Kensington, Md</i> | | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Harry Jones</i> | | | | | 14. MOTHER'S MAIDEN NAME
<i>Annie S. Sanford</i> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> | | | 16. SOCIAL SECURITY NO.
<i>(If you give war or dates of service)</i> | | 17. INFORMANT
<i>Barnett D. Incoe, 14412 N. H. Ave. SS</i> | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary / Colon & Melastosis</i>
<i>1538</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>1538</i>
DUE TO (c) <i>1538</i> | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>12-15 mo</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <i>19</i>
p.m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>1946</i> to <i>15 July, 1967</i> , that (I) (we) last saw the deceased alive on <i>13 July, 1967</i> , and that death occurred at <i>4:15</i> M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<i>William D. Aud</i> | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<i>7/15/67</i> | | |
| 22c. PHYSICIAN'S NAME (Type)
<i>WILLIAM D. AUD</i> | | | | | 22d. ADDRESS
<i>9006 Colverville Rd. Silver Sp. Md</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Buried</i> | | 23b. DATE THEREOF
<i>July 18, 1967</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Fort Lincoln Cemetery</i> | | 23d. LOCATION (City, town or county) (State)
<i>Colman Manor Pk. No. Md</i> | | | |
| 24. FUNERAL DIRECTOR
<i>Arthur Walters, 254 Carroll St NW Wash DC</i> | | | | | 25a. REC'D BY REGISTRAR
<i>DATE 19 1967</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |



52

1977

Wednesday

Dear Mary

2112 West 10th Ave

Portland, OR 97217

July 12

Dear Mary

Dear Mary

I hope you are well and happy.

I am writing you from the

University of Oregon

where I am a graduate student.

I

am

very

happy

to

hear

from

you

and

hope

you

are

well.

William D. And

Good Evening to Mary

Thank you for your letter of July 11, 1977.

I am sorry I cannot reply more quickly.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09775

CERTIFICATE OF DEATH

09780

| | | | |
|--|------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING</u> | | c. LENGTH OF STAY IN lb
<u>154</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SYLVAN MAJOR HEALTH CARE CENTER</u> | | d. STREET ADDRESS
<u>9907 OLD SPRING ROAD</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>ROSE</u> First <u>IZAKOFF</u> Middle Last | | 4. DATE OF DEATH
Month <u>JULY</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>MAR 25, 1884</u> |
| 9. AGE (In years last birthday)
<u>78</u> yrs. | | IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>RUSSIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>ISADORE POLONSKY</u> | | 14. MOTHER'S MAIDEN NAME
<u>EDITH LEAH</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO.
<u>DONE</u> | |
| 17. INFORMANT
<u>MORTON A. ROSEN</u> | | Address
<u>SAME AS 2</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4201</u> IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>
DUE TO (b) <u>Arteriosclerotic Heart Disease</u>
DUE TO (c) <u>years</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-4-1967</u> to <u>7-6-1967</u> , that (I) (we) last saw the deceased alive on <u>7-4-1967</u> , and that death occurred at <u>4:27</u> M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Irwin H. Ardan</u> | | 22b. DATE SIGNED
<u>7-6-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>IRWIN H. ARDAN, M.D.</u> | | 22d. ADDRESS
<u>1712-I-5th N.W. WASH. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>7-7-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>GEO. WASH. CEM</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>HYATTSVILLE MD</u> | |
| 24. FUNERAL DIRECTOR
<u>GRADACE FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 10 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09776

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09781

| | | | |
|---|-------------------------------|--|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN lb <u>24 days</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u>
b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Durham Hospital</u> | | d. STREET ADDRESS <u>R#2 Thompson Lane</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Ida May Jackson</u> | | 4. DATE OF DEATH <u>July 3 1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>10-17-36</u> |
| 9. AGE (years last birthday) <u>30</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>truck driver</u> | | 10b. INDUSTRY <u>Self Employed</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland, (Mont)</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Benjamin Jackson</u> | | 14. MOTHER'S MAIDEN NAME <u>Clara Brooks</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Wife (Frances Jackson) same as above</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRAIN ABSCESS</u>
DUE TO (b) <u>Fract. SKULL - comminuted + compound</u>
DUE TO (c) <u>Trauma -</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 DAYS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>changing truck tire. blew up - semi striking head</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>10:45 am 6/10 1967</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u> | | 20f. (City or town) (County) (State) <u>Rockville Montgomery MD</u> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Notural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John B. Ball</u> M.D. | | 22. DATE SIGNED <u>7/3/67</u> | |
| EXAMINER'S NAME (Type) <u>Robert L. Snowden</u> | | Address (Street, city, town, or county) <u>Rockville, Maryland</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7/7/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>ROUND OAK CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>SPENCERVILLE, MONTG. MD</u> | |
| 24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> | | 25a. RECEIVED BY REGISTRAR <u>Jul 8 1967</u> | |

10-1-12

Mr. J. H. Jones

Bellevue

Bellevue Hospital

Room 10-1-12

Dear Sir,

10-1-12

John

John

2nd Avenue

Manhattan

BOARD OF CHURCH

1111

1111

1111

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Cleared with Dr. Kapp

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|--------------------------------------|--|---|---|------------------------------------|--|--|--------------------------------------|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 09777 | | | | | CERTIFICATE OF DEATH | | | | | 09782 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Ind.</u> b. COUNTY <u>Montgomery</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | | | | c. LENGTH OF STAY IN 1b | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | | | | d. STREET ADDRESS
<u>508 Beall Ave</u> | | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 3. NAME OF DECEASED (Type or print)
<u>Odessa (Russian) Jarman</u> | | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>19</u> Year <u>1967</u> | | | | | | | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>Caucasian</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>7/18/67</u> | | 9. AGE (In years last birthday) yrs.
<u>1</u> | | 10. UNDER 1 YEAR
Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u> | | 11. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>—</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>—</u> | | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland - USA</u> | | | | |
| 13. FATHER'S NAME
<u>Leonard Jarman</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Brenda Barber</u> | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | | | | 16. SOCIAL SECURITY NO.
<u>—</u> | | | | | 17. INFORMANT
<u>A. Schachter</u> Address <u>Holy Cross Hospital</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>7545</u> IMMEDIATE CAUSE (a) <u>Congenital heart disease manifest by</u>
DUE TO
1) <u>Aortic valvular atresia</u>
(b) <u>2) Hyperplasia of lt. ventricle</u>
DUE TO
3) <u>Subendocardial sclerosis of lt. ventricle</u>
(c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Congestive heart failure</u> | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/19</u> , 19 <u>67</u> to <u>7/19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/19</u> , 19 <u>67</u> , and that death occurred at <u>8:55</u> M, from causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>M. n. Tabb mms</u> | | | | | 22b. DATE SIGNED
<u>7/19/67</u> | | | | | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Marvin Tabb, M.D.</u> | | | | | 22d. ADDRESS
<u>2401 Blairidge Ave., Wheaton, MD.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial-transit</u> | | | | | 23b. DATE THEREOF
<u>7/21/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Jarman Family Cemetery</u> | | | 23d. LOCATION (City or Town) (County) (State)
<u>Richland, N. Carolina</u> | | | | |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler</u> | | | | | ADDRESS
<u>Rockville, Maryland</u> | | | | | 25a. REC'D BY REGISTRAR
<u>JUL 25 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | |

STATE OF DEATH

1) Subarachnoid rupture of left ventricle
2) Rupture of left ventricle
3) Aortic valve disease
4) Congestive heart failure

Congestive heart failure

3401 Bridge Ave., Boston, Mo.

John Doe, M.D.

John Doe, M.D.

09778

CERTIFICATE OF DEATH

09783

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Released by Dr. Rogers (Cowan) 11 AM 7/6/67

| | | | |
|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town). <u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b <u>2 HRS.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1614 CROSS Hospital</u> | | d. STREET ADDRESS <u>9316 Piney Branch Rd</u> | |
| 3. NAME OF DECEASED (Type or print) <u>RUBY C. Jester</u> | | 4. DATE OF DEATH <u>7 2 1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>6/11/15</u> |
| 9. AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>J. William Phillips</u> | | 14. MOTHER'S MAIDEN NAME <u>Fraunce Brooks</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>J. M. Jester</u> | | Address <u>9316 - Piney Br. Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Generalized carcinoma</u>
DUE TO (b) <u>Carcinoma base of tongue</u>
DUE TO (c) <u>1410</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN CAUSE AND DEATH <u>12 mos.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>2</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3-6</u> , 1967, to <u>7-2</u> , 1967, that (I) (we) last saw the deceased alive on <u>6-30</u> 1967, and that death occurred at <u>3:50 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Harry N. Carlton</u> | | 22b. DATE SIGNED <u>7-2-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HARRY N. CARLTON</u> | | 22d. ADDRESS <u>8811 - Colesville Rd. S. S. Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>July 5-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rocky Lane</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville Montgoes Md.</u> |
| 24. FUNERAL DIRECTOR <u>Arthur Walters</u> | | 25a. REC'D BY REGISTRAR <u>JUL 5 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

THE STATE OF NEW YORK
IN SENATE
JANUARY 18, 1907
REPORT
OF THE
COMMISSIONER OF THE
DEPARTMENT OF CORRECTIONS
AND
REFORMATORY INSTITUTIONS
FOR THE YEAR
1906
ALBANY:
J. B. LEECH, STATE PRINTER
1907

09778

CERTIFICATE OF DEATH

09784

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|----------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton
c. LENGTH OF STAY IN 1b
3 months
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
University Nursing Home
901 Arcola Ave.
Wheaton, Md. | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Virginia
b. COUNTY
Alexandria
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
1728 Byron Street
d. STREET ADDRESS
1728 Byron Street
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 3. NAME OF DECEASED
(Type or print)
William Henry Jewell SR. | | | 4. DATE OF DEATH
Month 7 Day 22 Year 1967 | | |
| 5. SEX
Male | 6. COLOR OR RACE
Caus. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7/4/1877 | 9. AGE (In years last birthday)
90 yrs. | IF UNDER 1 YEAR
Months 7 Days 22 Hours 19 Min. 67 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
painter | | 10b. KIND OF BUSINESS OR INDUSTRY
Retired | | 11. BIRTHPLACE (County & State, or foreign country)
Leesburg, Virginia | |
| 12. CITIZEN OF WHAT COUNTRY?
USA | | | 13. FATHER'S NAME
Lewis Jewell | | |
| 14. MOTHER'S MAIDEN NAME
Mary Vonacker | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no
None | | |
| 16. SOCIAL SECURITY NO.
218-24-3740 | | | 17. INFORMANT
Annie E. McNeely
Address
Same As # 2 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1992
IMMEDIATE CAUSE (a) Carcinoma of Rectum
DUE TO (b) Lymphoid Colon with Metastases
DUE TO (c) 1992
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 year |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | | |
| 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 7/28 , 19 67 , to 7/22 , 19 67 , that (I) (we) last saw the deceased alive on July 22 1967 , and that death occurred at 8:30 P.M. from causes and on the date stated above. | | | | | |
| 22a. SIGNATURE
William Brainin | | 22b. DATE SIGNED
7/22/67 | | 22c. PHYSICIAN'S NAME (Type)
Dr. William Brainin | |
| 22d. ADDRESS
6124 Central Ave. Capitol Heights | | 22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/25/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | |
| 23d. LOCATION (City or Town) (County) (State)
Suitland, Maryland | | 24. FUNERAL DIRECTOR
W.W. Chambers Co. Inc.
517 11th St. S.E.
Washington, D.C. | | | |
| 25a. REC'D BY REGISTRAR
DATE JUL 27 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

STATE OF NEW YORK

1907

1. Name of decedent

Alexander

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

1. Name of decedent

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09780

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09785

| | | | |
|--|---|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
b. STATE <u>Md.</u> c. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lakema Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Lakema Park</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Wash. San. & Hospital</u> | | d. STREET ADDRESS
<u>8521 Glenview Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print)
<u>JOSEPH</u> | | 4. DATE OF DEATH
Month <u>JULY</u> Day <u>31</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-24-07</u> |
| 9. AGE (In years to birthday) yrs. <u>59</u> | | IF UNDER 1 YEAR
Months <u>5</u> Days <u>1</u> Hours <u>15</u> Min. <u>1</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Maintenance</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Good Acres</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>GEORGIA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Thomas Jones</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARIE HENDERSON</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Address</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Acute Coronary Insufficiency</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Heart Disease</u>
(c) <u></u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Read</u> M.D. | | 22. DATE SIGNED <u>July 31, 1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u> | | 23. NAME OF CEMETERY OR CREMATORY <u>Carver Memorial Park</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8-3-67</u> | |
| 23c. NAME OF FUNERAL HOME <u>John T. Rhines Co</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Prince Georges County, Md.</u> | |
| 24. FUNERAL DIRECTOR <u>John T. Rhines Co</u> | | 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

Handwritten notes, possibly a list or index, with some words like "Jones" and "Stacy" visible. The text is mirrored across the page.

United German American
Company (City of New York)

Handwritten notes at the bottom, including "Borden & Co." and "New York".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|---|
| 09781 | | 09786 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> | c. LENGTH OF STAY IN 1b
<u>10mo 9da</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington</u> 47.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Kensington Gardens San.</u> | | d. STREET ADDRESS
<u>4510 Conn. Ave N.W.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>INA B Jordan</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>4</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May 19, 1886</u> |
| 9. AGE (In years last birthday) yrs. <u>81</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Clerk U.S. Govt. Clerk</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Maine</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Unknown</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>Unknown</u> | |
| 16. SOCIAL SECURITY NO.
<u>579-60-678</u> | | 17. INFORMANT
<u>Baillargeon Funeral Home</u> Address <u>Old Town, Maine</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>
331X DUE TO
(b) <u>Thrombosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO
(c) <u>Atherosclerosis</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>hours</u>
<u>years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Possible pulmonary edema</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1961</u> to <u>July 4, 1967</u> , that (I) (we) last saw the deceased alive on <u>JULY 4</u> 19 <u>67</u> , and that death occurred at <u>6:32 PM</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert S. Poole</u> | | 22b. DATE SIGNED
<u>7.4.67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ROBERT S POOLE</u> | | 22d. ADDRESS
<u>4501 CONN AVE N.W. WASH DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Trans-burial</u> | 23b. DATE THEREOF
<u>July 8, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lawn Dale Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Old Town, Maine</u> |
| 24. FUNERAL DIRECTOR
<u>Clark E. Wilson</u>
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 10 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. Jago</u> |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

2582

1908

Old form, 1908

and in many cases, the

information is not complete

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

and is often incorrect

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09782

CERTIFICATE OF DEATH

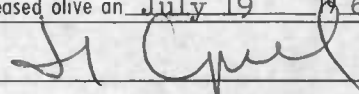
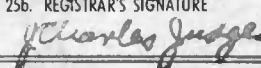
09782

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Wheaton
c. LENGTH OF STAY IN lb
1 mo.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
University Nursing Home | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring
d. STREET ADDRESS
2204 Washington Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Tillie none Kaufman | | | | 4. DATE OF DEATH
Month Day Year
7-9 1967 | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
8/23/1896 | | 9. AGE (In years lost birthday)
70 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
IF UNDER 24 HRS. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Russia | | | | 12. CITIZEN OF WHAT COUNTRY?
USA | | | |
| 13. FATHER'S NAME
Joseph Pecker | | | | 14. MOTHER'S MAIDEN NAME
Udel Abelman | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
218-16-9049 | | 17. INFORMANT
Mr. Morris Kaufman-2204 Washington Ave. | | | | Address | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of ovaries with metastases
DUE TO (b) metastases
DUE TO (c) metastases
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
8 months | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from June 6, 1967 to July 9, 1967 that (I) (we) last saw the deceased alive on July 9, 1967 , and that death occurred at 9:35 P.M. from causes and on the date stated above. | | | | | | | | | | | | | |
| 22a. SIGNATURE
William Brainin | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | 22b. DATE SIGNED
7/9/67 | | | | | |
| 22c. PHYSICIAN'S NAME (Type)
William Brainin, M.D. | | | | 22d. ADDRESS
6056 Central Ave. (Seat Pleasant Capital Heights, Md.) | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7-10-67 | | 23c. NAME OF CEMETERY OR CREMATORY
National Capital Hebrew Cem. Washington, DC | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| 24. FUNERAL DIRECTOR
B Danyanov & Sons | | | | ADDRESS WASHINGTON DC | | | | 25a. REC'D BY REGISTRAR
3501-14th St NW | | 25b. REGISTRAR'S SIGNATURE
J Charles Judge | | | |
| | | | | DATE JUL 12 1967 | | | | | | | | | |

09783

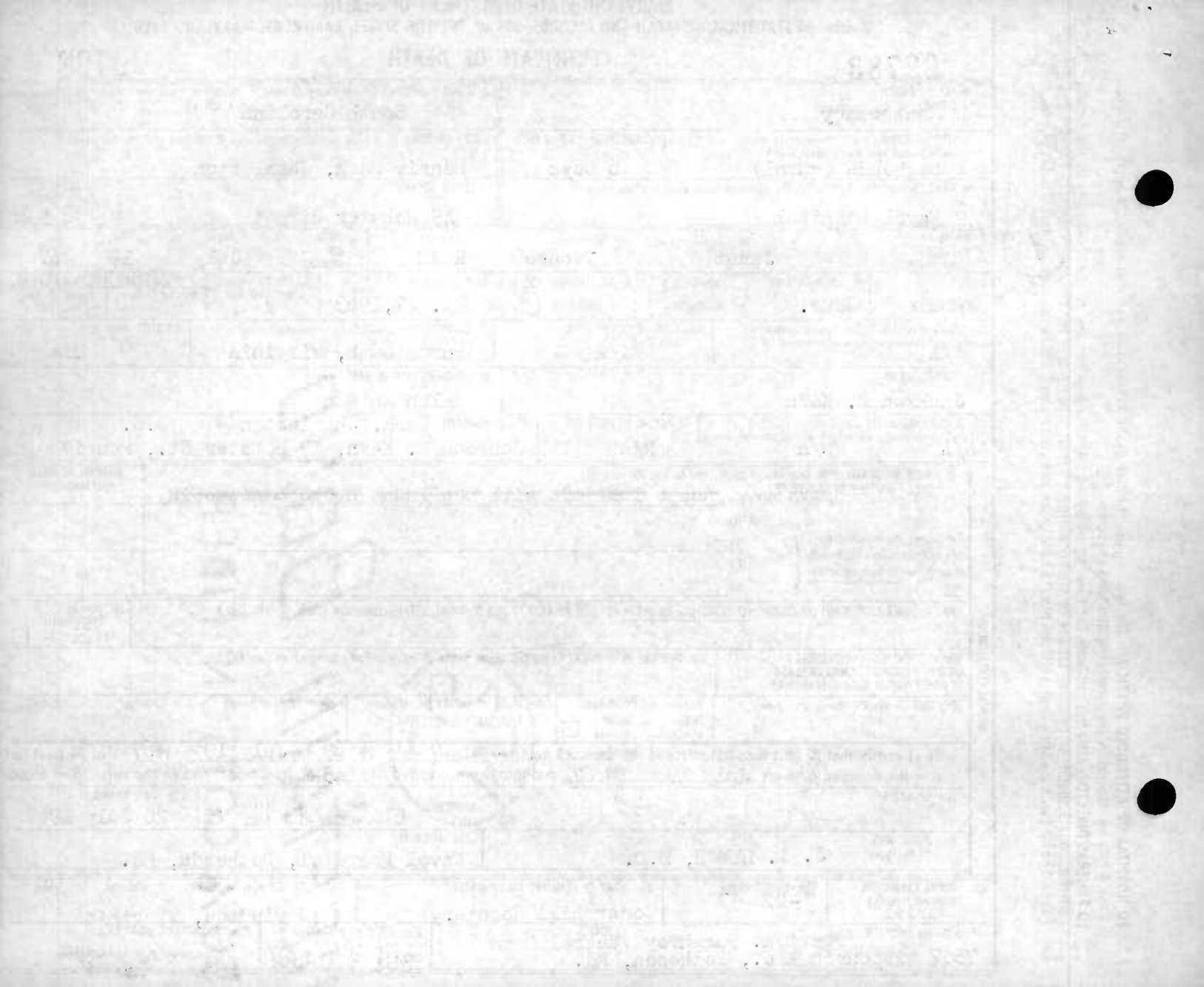
CERTIFICATE OF DEATH

09788

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE South Carolina b. COUNTY Charleston | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN 1b
46 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
49 Webster Street | |
| 3. NAME OF DECEASED
(Type or print)
Janet Yvonne KERN | | 4. DATE OF DEATH
Month July Day 19 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | B. DATE OF BIRTH
Oct. 27, 1963 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
N/A | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | 9. AGE (In years last birthday) yrs. 3 |
| 11. BIRTHPLACE (County & State, or foreign country)
Portsmouth, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Jackson R. Kern | | 14. MOTHER'S MAIDEN NAME
Helen Watson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give year or dates of service)
N/A | | 16. SOCIAL SECURITY NO.
N/A | 17. INFORMANT Park, Charleston S.C.
Jackson R. Kern, 49 Webster St., Menriv |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute leukemia with confluent bronchopneumonia
DUE TO (b) _____
DUE TO (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
2043 | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 7 , 19 67 , to July 19 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on July 19 , 19 67 , and that death occurred at 6:45 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
 | | 22b. DATE SIGNED
20 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
J. I. LYNCH, M.D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-22-67 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Covington, Virginia |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home
7557 Wisconsin Ave., Bethesda, Md. | | 25a. REC'D BY REGISTRAR
JUL 24 1967 | 25b. REGISTRAR'S SIGNATURE
 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

09789

09789

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
b. STATE <u>3 VIRGINIA</u> c. COUNTY <u>ARLINGTON</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BETHESDA</u> | | c. LENGTH OF STAY IN lb
<u>16 DAYS</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>BETHESDA - SILVER SPRING NURSING HOME</u>
<u>JONES Hill Rd.</u> | | d. STREET ADDRESS
<u>3931 NORTH 30TH ST.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
<u>WILHELMINA</u> <u>KIERNAN</u> | | 4. DATE OF DEATH
Month Day Year
<u>JULY</u> <u>13</u> <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12-30-89</u> |
| 9. AGE (In years lost birthday) yrs.
<u>77</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>BROOKLYN N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME | | 14. MOTHER'S MAIDEN NAME | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>UNKNOWN</u> | | 16. SOCIAL SECURITY NO.
<u>077-24-2072</u> | |
| 17. INFORMANT
<u>GEN. CHAS. G. NOLLE</u> | | Address
<u>2540 MASS. AVE. N.W.</u>
<u>WASH., D.C.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u>
DUE TO (b) <u>arteriosclerosis</u>
DUE TO (c) <u>coronary artery disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>months</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a). | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>June 27</u> , 19 <u>57</u> , to <u>July 13</u> , 19 <u>67</u> , that (I) (we) later saw the deceased alive on <u>July 12</u> , 19 <u>63</u> , and that death occurred at <u>1:00 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>[Signature]</u> | | 22b. DATE SIGNED
<u>July 13, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>BLAINE H. ETC</u> | | 22d. ADDRESS
<u>1641 Colsonville Rd Silver Spring Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
<u>7-17-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Arlington National</u> | 23d. LOCATION (City or town) (County) (State)
<u>Arlington Va</u> |
| 24. FUNERAL DIRECTOR
<u>[Signature]</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 17 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |

REPORT OF THE
COMMISSIONER OF THE LAND OFFICE

1899

THE LAND OFFICE OF THE STATE OF NEW YORK
HAS THE HONOR TO ACKNOWLEDGE THE RECEIPT OF
THE REPORT OF THE COMMISSIONER OF THE LAND OFFICE
FOR THE YEAR 1899, AND TO TRANSMIT THE SAME
TO THE SENATE, AS REQUIRED BY THE
ACT OF THE LEGISLATURE, PASSED
MARCH 1, 1899, CHAP. 108, SECTION 1.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|---|------------------------------------|
| 09785 | | 09791 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>7610 Arnet Lane</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Edmund J. Kinney</u> | | 4. DATE OF DEATH Month Day Year
<u>July 3 1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/26/1879</u> |
| 9. AGE (In years last birthday) <u>87</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Professor</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Mathias Kinney</u> | | 14. MOTHER'S MAIDEN NAME <u>Dorothy Ellen Applegate</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>405-42-5320</u> | |
| 17. INFORMANT <u>Sarah Schell</u> Address <u>same as deceased</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
4201 DUE TO (b) <u>Myocardial Infarction</u>
DUE TO (c) <u>Coronary artery atherosclerosis</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH
<u>few minutes</u>
<u>24 hours</u>
<u>15 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not White at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 2</u> , 19 <u>67</u> , to <u>July 3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 2</u> , 19 <u>67</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>K.H. Mish</u> | | 22b. DATE SIGNED <u>7-3-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>K.H. Mish</u> | | 22d. ADDRESS <u>3800 Jennifer St. N.W.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u> | | 23b. DATE THEREOF <u>7-4-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Lexington</u> | | 23d. LOCATION (City, town or county) (State) <u>Lexington Ky.</u> | |
| 24. FUNERAL DIRECTOR <u>Joseph Paulino Sam - Washington D.C.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u> | |

[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]

10/23/1888
 Edward J. Kennedy
 Jan 3

278
 Ohio
 Western Union
 1878

17 years
 2 1/2 lbs.
 for seed

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09786

09790

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN lb
<u>2 days</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Alice C. King</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>14</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11/10/02</u> |
| 9. AGE (In years lost birthday)
<u>64</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>14</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired practical nurse</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Nursing</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>China</u> | | 12. CITIZEN OF WHAT COUNTRY
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John A. Gere Shipley</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary E. Wood</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>232-62-1708</u> | |
| 17. INFORMANT
<u>Mrs. Lenora Jew</u> | | 18. ADDRESS
<u>11900 Rocking Horse Road, Rockville, Maryland</u> | |
| 19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Right temporal meningioma</u>
DUE TO (b) <u>223X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO (c) <u>223X</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Pituitary adenoma, pulmonary congestion & edema</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u>19</u> p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 21</u> , 19 <u>66</u> , to <u>July 14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 14</u> , 19 <u>67</u> , and that death occurred at <u>11:40 p.m.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Arnon H. Traum</u> | | 22b. DATE SIGNED
<u>July 17, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>ARNON H. TRAUM M.D.</u> | | 22d. ADDRESS
<u>7237 Georgia Ave. Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>July 19, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Moreland Memorial Park Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Baltimore, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Glen Carter</u>
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | 25. REC'D BY REGISTRAR
DATE <u>JUL 20 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

OFFICE OF THE DIRECTOR

1917

TO THE DIRECTOR OF THE BUREAU OF THE ARMY
FROM THE DIRECTOR OF THE BUREAU OF THE ARMY
SUBJECT: [Illegible]

1. [Illegible]
2. [Illegible]
3. [Illegible]
4. [Illegible]
5. [Illegible]
6. [Illegible]
7. [Illegible]
8. [Illegible]
9. [Illegible]
10. [Illegible]

11. [Illegible]
12. [Illegible]
13. [Illegible]
14. [Illegible]
15. [Illegible]
16. [Illegible]
17. [Illegible]
18. [Illegible]
19. [Illegible]
20. [Illegible]

21. [Illegible]
22. [Illegible]
23. [Illegible]
24. [Illegible]
25. [Illegible]
26. [Illegible]
27. [Illegible]
28. [Illegible]
29. [Illegible]
30. [Illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

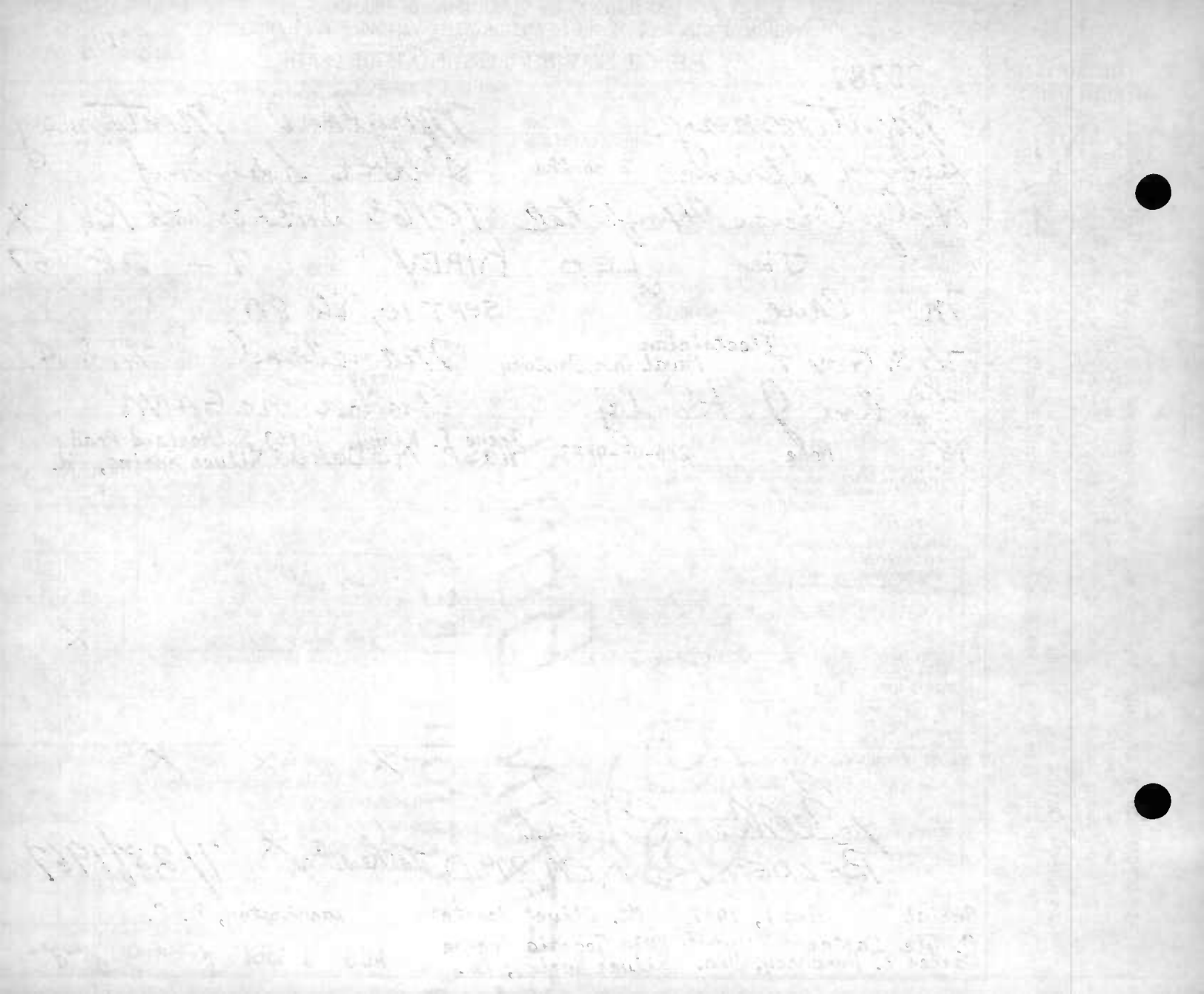
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09792

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. LENGTH OF STAY IN It <u>2 months</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u> | | d. STREET ADDRESS <u>10163 Sutherland Rd</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>John LEO KIRBY</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>28</u> Year <u>1967</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT. 10, '86</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | IF UNDER 1 YEAR
Months <u>7</u> Days <u>18</u> Hours <u>28</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. GOV'T</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Naval Gun Factory</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John J. Kirby</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna McGANN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u> | | 16. SOCIAL SECURITY NO. <u>216-45-9883</u> | |
| 17. INFORMANT <u>John E. Kirby</u> | | Address <u>10163 Sutherland Road</u>
<u>HOSP. RECORDS Silver Spring, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon</u>
DUE TO (b) <u>1538</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1538</u>
DUE TO (c) <u>1538</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | 22. DATE SIGNED <u>7/28/1967</u> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u> | | Address (State, city, and county) <u>Washington, D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>Aug 1, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u> | 23d. LOCATION (City or town) (County) (State) <u>Washington, D.C.</u> |
| 24. FUNERAL DIRECTOR <u>Glen Carter, Glen Bath</u> | | 25a. REC'D BY REGISTRAR <u>Charles Judge</u> | |
| Address <u>4834 Georgia Avenue</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| <u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | DATE <u>AUG 1 1967</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

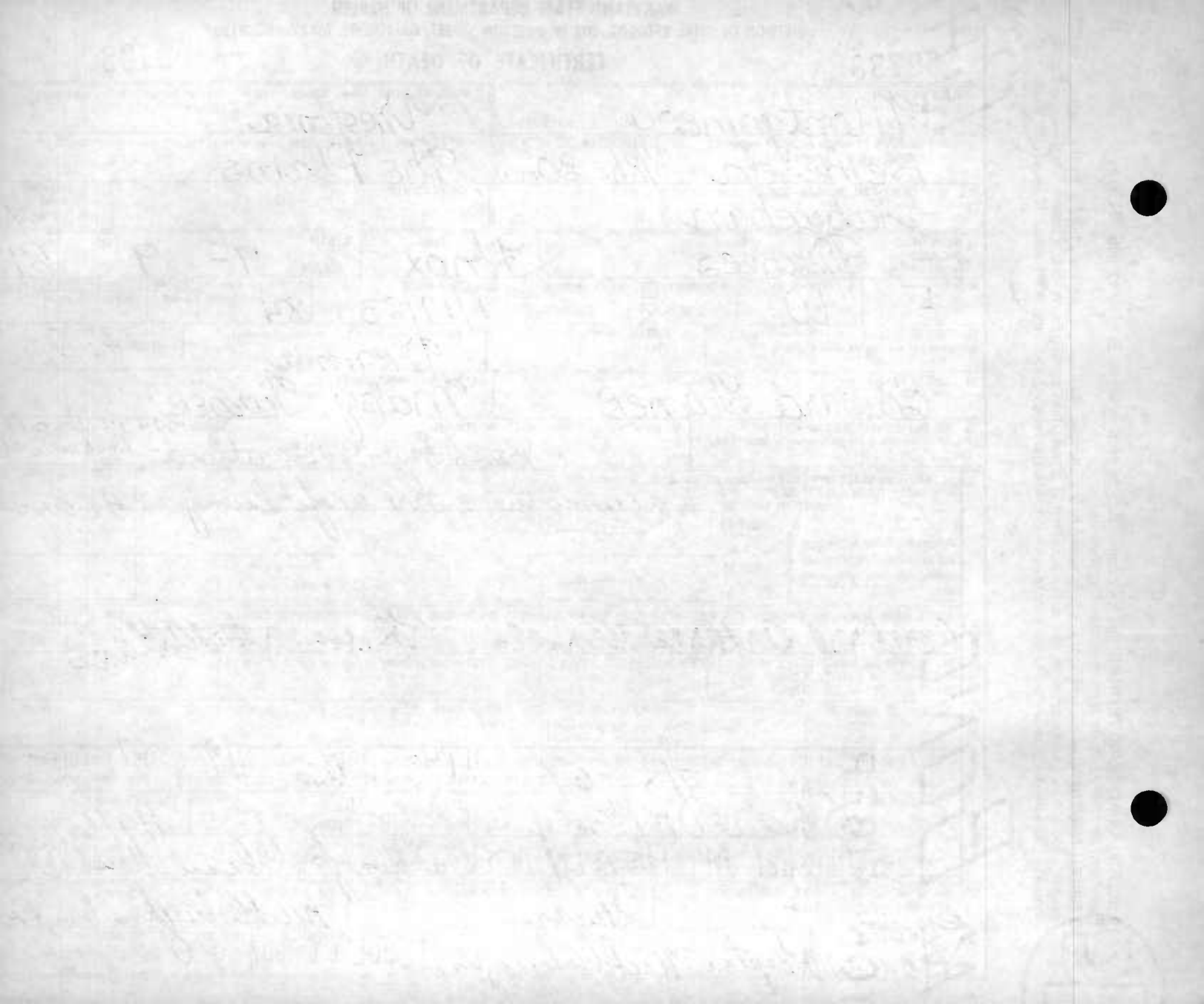
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|---|
| 09788 | | 09793 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>✓</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>The Plains</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>83-3</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Frances</u> First Middle Last | | 4. DATE OF DEATH <u>7-9-67</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1/19/83</u> |
| 9. AGE (In years last birthday) <u>84</u> yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Edward Turner</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary Turner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Son-in-Law - J. Blandford</u> | | Address <u>1994 Millbrook Dr Rockville, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia entire right lung</u>
DUE TO <u>48 hrs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>—</u>
DUE TO <u>—</u>
(c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u> | | 19. WAS AUTOPSY PERFORMED? <u>YES</u> <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Rheumatoid Arthritis</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/26</u> , 19 <u>65</u> to <u>7/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/8</u> , 19 <u>67</u> and that death occurred at <u>6:30</u> A.M., from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Michel M. Healy</u> M.D. | | 22b. DATE SIGNED <u>7/9/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Michel M. HEALY, M.D.</u> | | 22d. ADDRESS <u>Washington Clearing Wash DC</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>—</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Sharon</u> | 23d. LOCATION (City or town) (County) (State) <u>Nicholsburg, Va.</u> |
| 24. FUNERAL DIRECTOR <u>Louis Royton</u> | | 25a. REC'D BY REGISTRAR <u>Nicholsburg, Va.</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u> | | DATE <u>JUL 11 1967</u> | |



09794

09789

CERTIFICATE OF DEATH

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
<i>Montgomery</i>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Bethesda</i>
c. LENGTH OF STAY IN 1b
<i>DOA</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Suburban Hospital</i> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<i>Maryland</i>
b. COUNTY
<i>Montgomery</i>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Bethesda</i>
d. STREET ADDRESS
<i>5012 Elm St. Apt. A</i>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
XXXXXXXXXX
First Middle Last
<i>JAMES G. KREIMER</i> | | 4. DATE OF DEATH
Month Day Year
<i>July 26 1967</i> | |
| 5. SEX
<i>male</i> | 6. COLOR OR RACE
<i>white</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>MAR 23, 1903</i> |
| 9. AGE (in years last birthday)
<i>64</i> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Bus Driver</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>D. C. Transit</i> | |
| 11. BIRTHPLACE (Country & State, or foreign country)
<i>Frederick County Mt. Airy, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>Joseph Henry Kreimer</i> | | 14. MOTHER'S M maiden NAME
<i>ECKER, RHODA</i> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>578-10-5423</i> | |
| 17. INFORMANT
<i>Mary T. Kreimer - wife</i> | | 18. ADDRESS
<i>Old address as above</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>CORONARY THROMBOSIS</i>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>HYPERTENSIVE HEART DISEASE.</i>
DUE TO
(c) <i>10 YRS</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>INSTANT</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <i>19</i> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <i>JAN</i> , 1953, to <i>JULY</i> , 1967, that (I) (we) last saw the deceased alive on <i>JULY 18</i> , 1967, and that death occurred at <i>4 PM</i> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>DR. LEO I. DONOVAN</i> | | 22b. DATE SIGNED
<i>7-26-67</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>DR. LEO I. DONOVAN</i> | | 22d. ADDRESS
<i>8214 WILSONIAN AVE BETHESDA, MD</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | 23b. DATE THEREOF
<i>7-29-67</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Gate of Heaven Cem.</i> | 23d. LOCATION (City or Town) (County) (State)
<i>Silver Spring, Maryland</i> |
| 24. FUNERAL DIRECTOR
<i>ROBERT A. PUMPHREY, Bethesda, Maryland</i> | | 25a. REC'D BY REGISTRAR
DATE <i>JUL 28 1967</i> | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1892

(Signature)

St. Louis, Mo.

1000

1862

James M. Smith

24

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE District of Columbia COUNTY D.C. | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN lb
55 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | |
| 3. NAME OF DECEASED (Type or print)
First Susan Middle Olive Last KULBERG | | 4. DATE OF DEATH
Month July Day 14 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Nov. 12, 1949 |
| 9. AGE (In years last birthday) yrs. 17 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Student | |
| 11. BIRTHPLACE (State or foreign country)
Bradford, Massachusetts | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Harry O. Kulberg | | 14. MOTHER'S MAIDEN NAME
Mellicent McLagan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mr. Harry O. Kulberg, 1841 Columbia Rd. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchial Pneumonia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anoxic encephalopathy
DUE TO
(c) Respiratory arrest | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Over dose of Darvon | |
| 20c. TIME OF INJURY Month, Day, Year
? Hour o.m. xx I May 19 67 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town) (County) (State)
Washington D.C. | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE John G. Ball M.D. | | 22. DATE SIGNED
7-15-67 | |
| EXAMINER'S NAME (Type) John G. BALL | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) Bethesda, Md. | |
| 23a. BURIAL CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-18-67 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Home
7557 Wisconsin Ave., Bethesda, Md. | | 25a. REC'D BY REGISTRAR
JUL 19 1967 | |
| | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1931 National Ave., Bethesda, Md.

Robert A. Fanning, President

Washington National

Arlington, Virginia

John G. Ball

1-1-37

x

x

x

x

xx May 37

x None

Washington D.C.

Over date of birth

Respiratory arrest

Acute encephalopathy

Neonatal pneumonia

10

Harry O. Kilbey

William Morgan

Mr. Harry O. Kilbey, 1817 Columbia Rd.

N.W. Apt. 601

Wash. D.C.

Student

Bradford, Massachusetts

USA

Female

June

xx

Nov. 12, 1949

KILBEY

July

19

37

Naval Hospital

1817 Columbia Road, N.W. Apt.

601

Estados (mural)

55 days

Washington

District of Columbia

Montgomery

09796

09791

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|----------------------------|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | |
| c. LENGTH OF STAY IN 1b <u>1 mon 3 days</u> | | d. STREET ADDRESS <u>10116 Tenbrook Drive</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross of Silver Spring</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Alice S. HAMMER</u> | | 4. DATE OF DEATH <u>July 30 1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-9-89</u> |
| 9. AGE (In years last birthday) <u>77</u> | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u> | | 12. CITIZEN OF WHAT COUNTRY <u>USA</u> | |
| 13. FATHER'S NAME <u>Charles Faehle</u> | | 14. MOTHER'S MAIDEN NAME <u>Louise Hageman</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>496-38-1189</u> | |
| 17. INFORMANT <u>Mrs. Oliver F. Judge</u> | | 18. ADDRESS <u>10116 Tenbrook Drive Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiac Decomensation</u>
DUE TO (b) <u>Arterio sclerotic heart disease</u>
DUE TO (c) <u>Arteriosclerosis Bronchopneumonia</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fact. R & L. Lungs</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall in Nursing home</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>6/25/67</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/26/67</u> to <u>7/30/67</u> , that (I) (we) last saw the deceased alive on <u>7/30/67</u> , and that death occurred at <u>8 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Norman Oliver</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>NORMAN OLIVER</u> | | 22d. ADDRESS <u>1400 Spring St. Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>Aug. 2, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Belle Fontaine Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>St. Louis, Missouri</u> | |
| 24. FUNERAL DIRECTOR <u>Clark E. Warner</u> | | 25a. REC'D BY REGISTRAR <u>Aug 1 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | 25c. DATE | |

STATEMENT OF DEATH

1957

Montgomery
Alice
F. W.
7-8-89
Missouri
USA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the body papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|--|--|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| 09792 | | | |
| 09797 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY
<u>MONTGOMERY</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>BETESDA</u>
c. LENGTH OF STAY IN 1b
<u>21 1/2 HR</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>SUBURBAN</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>MARYLAND</u>
b. COUNTY
<u>MONTGOMERY</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING 151</u>
d. STREET ADDRESS
<u>2304 KANSAS AVE</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>WESLEY</u>
First Middle Last
<u>LANCASTER</u> | | 4. DATE OF DEATH
Month Day Year
<u>JULY 14 1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>NEGRO</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8/27/96</u>
9. AGE (In years lost birthday)
<u>70</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>NURSERY WORK</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country)
<u>MARYLAND</u> |
| 13. FATHER'S NAME
<u>LANCASTER</u> | | 14. MOTHER'S MARDEN NAME
<u>Cecilia</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | 17. INFORMANT
<u>BESSIE LANCASTER - WIFE SAME</u>
Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary insufficiency</u>
DUE TO
(b) <u>Coronary arteriosclerosis</u>
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | INTERVAL BETWEEN ONSET AND DEATH
<u>24 hours</u>
years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Primary cholangio-carcinoma, left lobe of liver</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19</u> , to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>1047 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>George Shaye</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
| <u>BURIAL</u> | <u>7/18/67</u> | <u>ASH MEMORIAL</u> | <u>Sandy Spring, Montg, Md</u> |
| 24. FUNERAL DIRECTOR
<u>George R. Anorden</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 18 1967</u> | |
| | | 25b. REGISTRAR'S SIGNATURE
<u>John J. Jones</u> | |

STATE OF TEXAS

and no other

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09793

CERTIFICATE OF DEATH

09798

| | | | |
|--|------------------------------|--|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>NEW YORK</u> b. COUNTY <u>Dutchess</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>TAKOMA PARK</u> | | c. LENGTH OF STAY IN 1b
<u>39 days</u> | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Pine Plains</u> | | 69.3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>WASHINGTON SANITARIUM + HOSPITAL</u> | | d. STREET ADDRESS | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Emily</u> Middle <u>Louina</u> Last <u>LANGDON</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>9</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>11-6-79</u> |
| 9. AGE (In years, lost birthday)
<u>87</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Own home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>NEW YORK</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A</u> | |
| 13. FATHER'S NAME
<u>WILLIAM SMITH</u> | | 14. MOTHER'S MAIDEN NAME
<u>MARY HOWARD</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> <u>None</u> | | 16. SOCIAL SECURITY NO.
<u>070-38-3489</u> | |
| 17. INFORMANT
<u>Mary J. Fitzgerald</u> | | 18. ADDRESS
<u>4 Manchester Place Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Extensive Peritonitis</u>
5410
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Ruptured Duodenal Ulcer</u>
(c) <u> </u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Sanitary</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> o.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Dec 20, 1964</u> , to <u>July 9, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1967</u> , and that death occurred at <u>7:54 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Philip E. Jones</u> | | 22b. DATE SIGNED
<u>7/9/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Philip E. Jones MD</u> | | 22d. ADDRESS
<u>800 Pershing Drive Silver Spring, Md. 20910</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 23b. DATE ATHEROOF
<u>July 12, 1967</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Fort Lincoln Crematory</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges Co., Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>Glen Carter</u> | | 25a. REC'D BY REGISTRAR
<u>Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>JUL 11 1967</u> | |

DECLARATION OF DEATH

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

1912

09794

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETESDA
c. LENGTH OF STAY IN TB
15 1/2 HRS. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SUBURBAN Hospital | | d. STREET ADDRESS
1514 LIVE OAK DRIVE
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Emily Kane LAST | | 4. DATE OF DEATH
Month Day Year
JULY 23 1967 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8/23/12
8/23/12
9. AGE (In years lost birthday)
54 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | 11. BIRTHPLACE (County & State, or foreign country)
PENNA |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A | | 13. FATHER'S NAME
FELIX KANE | |
| 14. MOTHER'S MAIDEN NAME
Emily Dugan | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, (unknown)) (If yes give war or dates of service)
NO None | |
| 16. SOCIAL SECURITY NO.
577-18-1952 | | 17. INFORMANT
PAUL V. LAST - HUSBAND - SAME | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201
DUE TO (b) coronary artery & thrombosis
DUE TO (c) arteriosclerotic Heart Disease | | INTERVAL BETWEEN ONSET AND DEATH
56 hrs
36 hrs | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 21 July 1967 to 23 July 1967 , that (I) (we) last saw the deceased alive on 23 July 1967 , and that death occurred at 10:54 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Merton L. White M.D. | | 22b. DATE SIGNED
23 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
Merton L. White, M.D. | | 22d. ADDRESS
9911 Georgia Ave Silver Spring | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
July 26, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Gate of Heaven Cemetery | 23d. LOCATION (City or Town) (County) (State)
Silver Spring, Maryland |
| 24. FUNERAL DIRECTOR
John B. Thomas
Warner E. Humphrey, Inc. | | 25a. REC'D BY REGISTRAR
John B. Thomas
4434 Georgia Avenue
Silver Spring, Md. | |
| 25b. REGISTRAR'S SIGNATURE
John B. Thomas | | DATE
JUL 27 1967 | |

STATE OF OHIO

Division

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|----------------------------------|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery County</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u> | | | | c. LENGTH OF STAY IN 1b <u>75 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Blomberg Valley Nursing Home</u> | | | | | | d. STREET ADDRESS <u>6409 East Halbert Rd.</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Rose</u> First Middle Last | | | | | | 4. DATE OF DEATH Month <u>7</u> Day <u>17</u> Year <u>1967</u> | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 4 1890</u> | | 9. AGE (In years lost birthday) <u>76</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) <u>Austria</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME | | | | | | 14. MOTHER'S MAIDEN NAME <u>CELIA STISTEL</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT <u>Mrs. Anita Bickford Bethesda, Md.</u> Address <u>6409 E. Halbert</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebrovascular arteriosclerosis</u>
DUE TO (b) <u>334X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture of hip - remote</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May 3</u> , 19 <u>67</u> to <u>July 17</u> , 19 <u>67</u> , that (I) <u>last</u> saw the deceased alive on <u>June 24</u> , 19 <u>67</u> , and that death occurred at <u>1:45 A.M.</u> from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>Harold C. Sadin</u> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>7/17/67</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>HAROLD C. SADIN M.D.</u> | | | | 22d. ADDRESS <u>2141 K. St. N.W., WASHINGTON, D.C.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/18/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Mount Hebron</u> | | | | 23d. LOCATION (City or Town) (County) (State) <u>Flushing, Long Island, N.Y.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Donald M. Stein</u> | | | | ADDRESS <u>232 Carroll St. Wash., D.C.</u> | | | | 25a. REC'D BY REGISTRAR <u>AUL 19 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| Hebrew Memorial Funeral Home | | | | | | | | | | | |

STATE OF TEXAS
COUNTY OF DALLAS

I, the undersigned, Judge of the County of Dallas, Texas, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of Dallas, Texas.

Given under my hand and the seal of the County of Dallas, Texas, this 1st day of January, 1901.

My commission expires this 1st day of January, 1902.

Witness my hand and the seal of the County of Dallas, Texas, at Dallas, Texas, this 1st day of January, 1901.

Judge of the County of Dallas, Texas.

County Clerk of the County of Dallas, Texas.

Notary Public for the County of Dallas, Texas.

Attorney at Law for the County of Dallas, Texas.

Witness my hand and the seal of the County of Dallas, Texas, at Dallas, Texas, this 1st day of January, 1901.

Judge of the County of Dallas, Texas.

County Clerk of the County of Dallas, Texas.

Notary Public for the County of Dallas, Texas.

Attorney at Law for the County of Dallas, Texas.

Witness my hand and the seal of the County of Dallas, Texas, at Dallas, Texas, this 1st day of January, 1901.

Judge of the County of Dallas, Texas.

County Clerk of the County of Dallas, Texas.

Notary Public for the County of Dallas, Texas.

09796

CERTIFICATE OF DEATH

09801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|---|----------------------------------|---|--------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>New York</u> b. COUNTY <u>Broont New York</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Winston</u> | | c. LENGTH OF STAY IN 1b
<u>48 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Broont New York</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Bandagee Heels Nursing Home 4011 Bonneyhall</u> | | | | d. STREET ADDRESS
<u>35 East 208th St</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Samuel</u> Middle <u>Lerner</u> Last <u>Lerner</u> | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>5</u> Year <u>1967</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>4/15/1885</u> | | 9. AGE (In years lost birthday)
<u>82</u> yrs. | IF UNDER 1 YEAR
Months <u>5</u> Days <u>19</u> Hours <u>14</u> Min. <u>67</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Salesman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Romania</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Isaac Lerner</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Chaya Harris</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT
<u>Harold Lerner, son - 14124 Bauer Drive Rockville, Md.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u>
334X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <u>Generalized Arteriosclerosis</u>
DUE TO
(c) <u>14R</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>6 mos</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Recurrent Cystitis</u> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>67</u> , to <u>7/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/4</u> , 19 <u>67</u> , and that death occurred at <u>4:30 AM</u> , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Raymond T. Benack</u> | | | | 22b. DATE SIGNED
<u>7/5/67</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>RAYMOND T. BENACK MD</u> | |
| 22d. ADDRESS
<u>4115 Colie Drive, Wheaton, MD</u> | | | | 22e. REC'D BY REGISTRAR
<u>JUL 6 1967</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/7/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Lebanon Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Brooklyn, N.Y.</u> | |
| 24. FUNERAL DIRECTOR
<u>B Dargansky & Sons</u> | | | | 25. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

CERTIFICATE OF DEATH

| | | | | | | | | | |
|---------------------------------|--|---------------------------------------|--|---------------------------------------|--|---|--|--|--|
| 1. Name of deceased | | 2. Sex | | 3. Race | | 4. Date of birth | | 5. Date of death | |
| 6. Place of birth | | 7. Usual residence | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | |
| 11. Signature of registrar | | 12. Signature of informant | | 13. Signature of medical examiner | | 14. Signature of coroner | | 15. Signature of funeral director | |
| 16. Signature of health officer | | 17. Signature of local health officer | | 18. Signature of state health officer | | 19. Signature of federal health officer | | 20. Signature of national health officer | |

U.S. NATIONAL BUREAU OF HEALTH RECORDS
WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

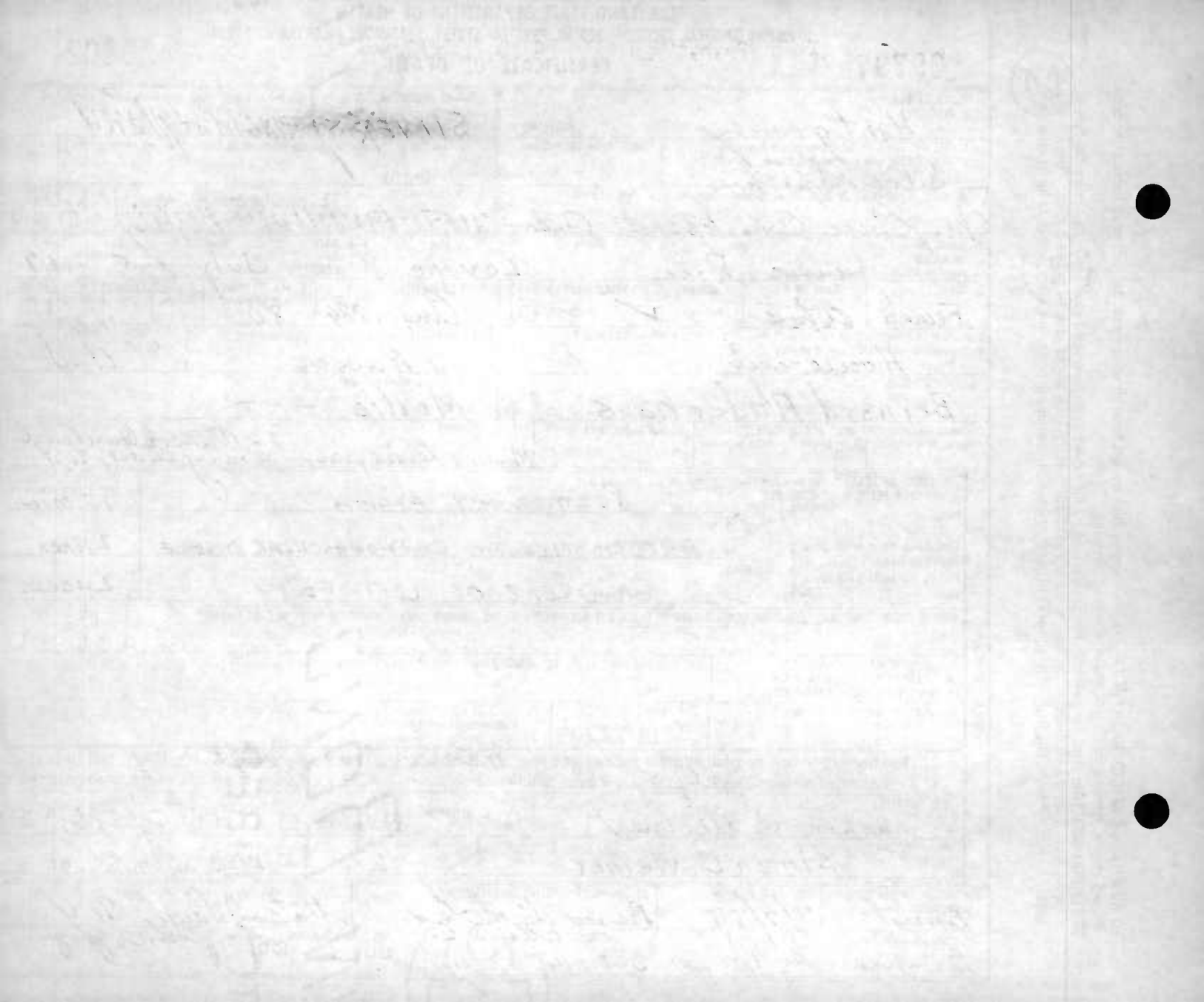
VR A15 (4)
25M 1/67

09797

CERTIFICATE OF DEATH

09302

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
<u>SILVER SPRING MARYLAND</u>
b. COUNTY <u>MD</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN 1b
<u>69.3</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Chen Chase Convalescent Center</u> | | d. STREET ADDRESS
<u>1651 Montgomery Ave.</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Levine Rose</u> | | 4. DATE OF DEATH
<u>July 5 1967</u> | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>Aug. 1886</u> | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 9b. AGE (In years last birthday)
<u>80</u> yrs. | |
| 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Russia</u> | |
| 13. FATHER'S NAME
<u>Bernard Aiderhaus</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mollie</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 17. INFORMANT
<u>Murray Levine, son</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>
DUE TO
(c) <u>GANGRENE OF LEFT FOOT</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>13 min.</u>
<u>2 YEARS</u>
<u>2 WEEKS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>March 21, 1967</u> to <u>July 5, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 5, 1967</u> , and that death occurred at <u>M</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Simon C. Weiner</u> | | 22b. DATE SIGNED
<u>7/5/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Simon C. Weiner</u> | | 22d. ADDRESS
<u>8201-16 ST. SILVER SPRING MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/7/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Baron Hirsch Gen.</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Staten Island N.Y.</u> | |
| 24. FUNERAL DIRECTOR
<u>B Danyanovsky & Sons</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 1 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | |



CERTIFICATE OF DEATH

09798

09803

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE WASH., DC b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
47-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
HOLY CROSS HOSPITAL | | d. STREET ADDRESS
2480 16th ST., N.W. | |
| 3. NAME OF DECEASED
(Type or print)
First SARAH Middle Last LEVY | | 4. DATE OF DEATH
Month 7 Day 30 Year 1967 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
MARCH 15, 1887 |
| 9. AGE (In years lost birthday)
80 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | |
| 11. BIRTHPLACE (County & State, or foreign country)
Poland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
CHAIM BLOCHARSKY | | 14. MOTHER'S MAIDEN NAME
RASHA --- | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Jeanette Behrman, 9320 Grey-rock Rd. S.S.Md. | | Address 9320 Grey-rock Rd. S.S.Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarction
DUE TO (b) Coronary disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hepaticomegaly, Thrombopenia cause undetermined | | | INTERVAL BETWEEN ONSET AND DEATH
1 yr. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 7/15 , 19 67 , to 7/30 , 19 67 , that (I) (we) last saw the deceased alive on 7/30 , 19 67 , and that death occurred at 11:20 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Blaine H. H. H. | | | 22b. DATE SIGNED
July 30, 1967 |
| 22c. PHYSICIAN'S NAME (Type)
BLAINE H. H. H. | | | 22d. ADDRESS
2641 Colomille Rd. Silver Spring, Md. |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7/31/67 | 23c. NAME OF CEMETERY OR CREMATORY
Elesvatgrad Cemetery | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. |
| 24. FUNERAL DIRECTOR
B. Danzansky + Son | | | 25a. REC'D BY REGISTRAR
AUG 1 1967 |
| ADDRESS
3501-14th St NW | | | 25b. REGISTRAR'S SIGNATURE
J. J. J. |

MEMBER'S NAME: MONTGOMERY, JAMES

RESIDENCE: 12345

DATE OF BIRTH: 1925

SEX: M

AGE: 30

RELIGION: X

EDUCATION: 12

EMPLOYMENT: 12345

DATE OF DEATH: 1955

DATE OF BURIAL: 1955

DATE OF INTERMENT: 1955

DATE OF CREMATION: 1955

DATE OF BURIAL: 1955

DATE OF BURIAL: 1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|---|---|--------------------------------------|
| 09793 | | 09804 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rockville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Kensington</u> 15/1 | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS
<u>4407 Ambler Drive</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Potomac Valley Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>Stewart</u> Middle <u>Pierce</u> Last <u>Lewis</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>25</u> Year <u>1967</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>8-22-89</u> |
| 9. AGE (In years lost birthday)
<u>77</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>7</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Mechanical engineer-U.S. Government</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Scranton, Pa.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>William B. Lewis</u> | | 14. MOTHER'S MAIDEN NAME
<u>Mary Powell</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>275-26-4512</u> | |
| 17. INFORMANT
<u>Mary A. Lewis same as #2</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>cardio-pulmonary failure</u>
DUE TO (b) <u>generalized carcinomatosis</u>
DUE TO (c) <u>Bronchogenic Ca.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 hrs</u>
<u>6 mos.</u>
<u>345</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>6/10/67</u> , 19 <u>67</u> to <u>7/25/67</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/24</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John M. Wyman</u> | | 22b. DATE SIGNED
<u>7/25/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN M WYMAN M.D.</u> | | 22d. ADDRESS
<u>7801 NORFOLK AVE. BETHESDA, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>burial</u> | | 23b. DATE THEREOF
<u>7/28/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges County, Md</u> | |
| 24. FUNERAL DIRECTOR
<u>The S.H. Hines Company</u>
<u>2901 14th St. N.W. Washington, D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 26 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | 25c. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | |

REPORT OF PROGRESS

1907

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

W. H. HARRIS

CERTIFICATE OF DEATH

09805

09800

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
<u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Takoma Park</u>
c. LENGTH OF STAY IN 1b
<u>15</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Washington Sanitarium & Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
<u>Maryland</u>
b. COUNTY
<u>MONTGOMERY</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u>
d. STREET ADDRESS
<u>8104 Takoma Drive</u>
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
<u>Joseph</u>
First Middle Last
<u>(NMN) Lieberman</u> | | 4. DATE OF DEATH
Month Day Year
<u>7</u> <u>28</u> <u>1967</u> | |
| 5. SEX
<u>MALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Sept. 2-1891</u>
9. AGE (In years last birthday) yrs.
<u>75</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Supervisor</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Theater</u> | 11. BIRTHPLACE (County & State, or foreign country)
<u>Hungary</u> |
| 13. FATHER'S NAME
<u>Lieberman</u> | | 14. MOTHER'S MAIDEN NAME
<u>Sarah</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>UNKNOWN</u> | |
| 17. INFORMANT
<u>Patient's Chart</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4201 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO (b) <u>MYOCARDIAL INFARCT</u>
DUE TO (c) <u>CORONARY ARTERY DISEASE</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>DIABETES MELLITIS C I F</u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-26</u> , 19 <u>67</u> , to <u>7-28</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-28</u> , 19 <u>67</u> , and that death occurred at <u>1145</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John L. Ford</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED
<u>7-28-67</u> |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN L. FORD, MD</u> | | 22d. ADDRESS
<u>831 UNIVERSITY BLVD. SILVER SPRING, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>7-30-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Mt. Lebanon</u> | 23d. LOCATION (City or Town) (County) (State)
<u>COLLINGDALE, PA.</u> |
| 24. FUNERAL DIRECTOR
<u>Frederick Funeral Home</u>
<u>4217 9th St. NW.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>AUG 1 1967</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Young</u> |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

RECEIVED
DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C.

Noted

1881-82
X

White

Unknown

Commissioner

Received
1881-82

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Clear by Medical Examiner Peter Ray M.D. J. J. [Signature]

4 STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

09806

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Rockville | | c. LENGTH OF STAY IN 1b
4 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
4616 Harlan Street | | d. STREET ADDRESS
1603 Jefferson Street | |
| 3. NAME OF DECEASED (Type or print)
MAMIE ELIZABETH LOHMEYER | | 4. DATE OF DEATH
JULY 10 1967 | |
| 5. SEX
female | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Dec 8, 1888 | |
| 9. AGE (In years last birthday)
78 yrs. | | 10. UNDER 1 YEAR
Months Days Hours Min. | |
| 11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 12. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 13. BIRTHPLACE (County & State, or foreign country)
Washington, D. C. | | 14. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 15. FATHER'S NAME
George Owens | | 16. MOTHER'S MAIDEN NAME
Sarah Little | |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
No | | 18. SOCIAL SECURITY NO.
587-22-7810 | |
| 19. INFIRMANT
Harry E. Lohmeyer, Jr. | | Address
4616 Harlan St. Rockville, Md. | |
| 19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus | | INTERVAL BETWEEN ONSET AND DEATH
2 hrs.
years | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Sept 1955 to July 5, 1967 , that (I) (we) last saw the deceased alive on July 5, 1967 , and that death occurred at 12:22 PM , from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
James R. Coleman | | 22b. DATE SIGNED
July 10, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
JAMES R. COLEMAN | | 22d. ADDRESS
9241 COLUMBIA BLVD SILVER SPRING MARYLAND | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 13, 1967 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | 23d. LOCATION (City, town or county) (State)
Rockville, Maryland | |
| 24. FUNERAL DIRECTOR
Glen Carter, 8434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md. | | 25a. RECD BY REGISTRAR
JUL 13 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. [Signature] | | DATE | |

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

09807

09802

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | |
| c. LENGTH OF STAY IN 1b <u>316 days</u> | | d. STREET ADDRESS <u>4404 Brookfield Dr.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>John Alphonsis Loughran</u> | | 4. DATE OF DEATH <u>July 2 1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>4-30-91</u> |
| 9. AGE (In years, lost birthday) <u>76</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt.</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u> | |
| 13. FATHER'S NAME <u>John Loughran</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie Kinney</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>W.W.I.</u> | | 16. SOCIAL SECURITY NO. <u>unknown</u> | |
| 17. INFORMANT <u>Med. records</u> | | Address <u>Wash. San. Hosp.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>1561</u> IMMEDIATE CAUSE (a) <u>Carcinoma of liver</u>
DUE TO (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____
DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 YRS</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>uremia</u> | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>3/2</u> , 19 <u>65</u> , to <u>7/2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/1</u> , 19 <u>67</u> , and that death occurred at <u>4:32 PM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Henry W. Stout MD</u> | | 22b. DATE SIGNED <u>7/2/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>HENRY W. STOUT MD</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, or other disposition <u>Burial</u> | 23b. DATE THEREOF <u>7-5-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | 23d. LOCATION (City or Town) (County) (State) <u>Baltimore Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Robert A Pumphrey</u> | | 25a. REC'D BY REGISTRAR <u>JUL 6 1967</u> | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> |

5222

ndel

09803

CERTIFICATE OF DEATH

09808

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia b. COUNTY Virginia | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Alexandria 83-3 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First Leland Middle P. Last LOVETTE | | 4. DATE OF DEATH
Month July Day 10 Year 1967 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 11, 1897 |
| 9. AGE (In years last birthday)
69 yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Navy | |
| 11. BIRTHPLACE (County & State, or foreign country)
Greenville, Tennessee | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Oscar Byrd Lovette | | 14. MOTHER'S MAIDEN NAME
Lillie Fowler | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes 1917-1949 | | 16. SOCIAL SECURITY NO.
1917-1949 | |
| 17. INFORMANT
Tennessee | | Address
Capt. Wendell F. Kline, USN, Ret. Sewanee | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Perforated duodenal ulcer with peritonitis
DUE TO
5411
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) DUE TO
(c) DUE TO | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that he (this hospital) attended the deceased from May 29 , 19 67 , to July 10 , 19 67 , that he (we) lost saw the deceased alive on July 10 , 19 67 , and that death occurred at 8:00 M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
W. J. FORTY | | 22b. DATE SIGNED
July 12, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
W. J. FORTY, M. D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-14-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR'S NAME (Type)
Falls Church Funeral Home | | 25a. REC'D BY REGISTRAR
JUL 17 1967 | |
| 25b. ADDRESS
1102 West Broad Street, Falls Church, Virginia | | 25c. PREPARED BY
James D. Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

000003

DEPARTMENT OF DEFENSE

Virginia

Montgomery

Albuquerque

12 days

Testimony (oral)

2000 Glen Drive, Dallas, Texas

Navy Hospital

WHITE

Latino

Dec. 11, 1957

June

Male

Greenwood, Tennessee

U. S. Navy

Little River

Great River, Tennessee

Gen. Marshall S. Kilgus, USA, Ret., Tennessee

1917-1919

Testimony furnished after oral examination

July 10, 1957

July 10, 1957

Navy Hospital, Norfolk, VA

U. S. Navy, U. S.

Arlington, Virginia

Washington National

Ball's Chapel Funeral Home

1902 First Street, Tallahassee, Florida

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2 Cleared by med. for Dr. Perez

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|-------------------------------|---|---------------------------------|
| 09804 | | 09809 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | |
| c. LENGTH OF STAY in 1b <u>3 days</u> | | d. STREET ADDRESS <u>8505 Glenview Ave.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Shirley E. LUTSKY</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>22</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-15-27</u> |
| 9. AGE (In years lost birthday) <u>44</u> yrs. | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ADMINISTRATIVE ASST. LABOR DEPT. U.S. NAVY</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>ISIDORE NEWMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>LENA BERNAN</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES WWII</u> | | 16. SOCIAL SECURITY NO. <u>086-12-5358</u> | |
| 17. INFORMANT <u>MORRIS LUTSKY</u> | | Address <u>8505 GLENVIEW, AVE. TAKOMA, PK. MD.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u>
330X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Ruptured Intracranial Aneurysm</u>
(c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>19</u> a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7-20</u> , 19 <u>67</u> , to <u>7-22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7-22</u> , 19 <u>67</u> , and that death occurred at <u>8 P.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Dallazar E. Perez</u> | | 22b. DATE SIGNED <u>7-23-67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dallazar E. Perez</u> | | 22d. ADDRESS <u>10305 Folk St. Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7-23-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>D.C. Lodge</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u> | |
| 24. FUNERAL DIRECTOR <u>Goldberg Funeral Home 4217-9th St. N.W.</u> | | 25a. REC'D BY REGISTRAR <u>JUL 25 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

1082

HIA30 10 HADHND

032

084-12332



CERTIFICATE OF DEATH

09811

M 09806

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda
c. LENGTH OF STAY IN 1b
48 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Virginia
b. COUNTY
Vienna
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
First Middle Last
Daniel Alonzo Mahaffey | | 4. DATE OF DEATH
Month Day Year
July 30 1967 | |
| 5. SEX
M | 6. COLOR OR RACE
Cauc | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
17 March 1926 |
| 9. AGE (In years lost birthday)
41 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
30 19 67 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
KINGS MOUNTAIN, N.C. | | 12. CITIZEN OF WHAT COUNTRY?
U. S. | |
| 13. FATHER'S NAME
Sidney C. Mahaffey | | 14. MOTHER'S MAIDEN NAME
Lucille Gilliam | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW II- Korean | | 16. SOCIAL SECURITY NO.
247 32 6538 | |
| 17. INFORMANT
Joyce Mahaffey | | Address
2441 Shennandoah Street Vienna, Virginia | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hodgkins Disease
201X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) DUE TO
(c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 12 June , 19 67 , to 30 July , 19 67 , that (X) (we) last saw the deceased alive on 30 July , 19 67 , and that death occurred at 10:08 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>J. B. Emery, M.D.</i> | | 22b. DATE SIGNED
31 July, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
J. B. Emery, M.D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Maryland | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | 23b. DATE THEREOF
8/3/67 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National Cemetery | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR
Money and King, Maple Avenue, Virginia | | 25a. REC'D BY REGISTRAR
DATE AUG 7 1967 | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. J...</i> |

CERTIFICATE OF DEATH

28808

Virginia

Montgomery

Virginia

18 Days

Harrisburg

State Department of Health

Local Hospital

1918

1918

Montgomery

1918

Local

IX March 1918

Cause

KLING MONTGOMERY, R.C.

Local Hospital

Edwin C. Montgomery

State Department of Health
Virginia, Richmond

Local Hospital

WM III - Johnson

Yes

Hospital Name

12 June 1918

1918

[Handwritten signature]

Local Hospital

J. H. Smith

Washington National Cemetery, Arlington, Virginia

Montgomery and Kling, Virginia

CERTIFICATE OF DEATH

09807

09812

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> <u>MD.</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Colonial Villa Nursing Home</u> | | d. STREET ADDRESS
<u>W. MARKET ST.</u> | |
| 3. NAME OF DECEASED
(Type or print)
First <u>MARIE</u> Middle <u>EMMA</u> Last <u>MAI</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>30</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>7-16-88</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Reservation Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Hotel</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Delaware</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>CHARLES F. MAI</u> | | 14. MOTHER'S MAIDEN NAME
<u>ANNA MARIE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>L</u> | | 16. SOCIAL SECURITY NO.
<u>181-07-6720-A</u> | |
| 17. INFORMANT
<u>CHARLES MAI</u> | | Address
<u>50 HAWKES BURY LANE SILVER SPRING, MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral infarction</u>
DUE TO (b) <u>Cerebral arteriosclerosis</u>
DUE TO (c) <u>Generalized arteriosclerosis</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Chronic brain syndrome secondary to cerebral arteriosclerosis</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II as applicable) | |
| 20c. TIME OF INJURY
Hour <u>a.m.</u> Month <u>19</u> Day <u>19</u> Year <u>1967</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (this hospital) attended the deceased from <u>6-5</u> , 19 <u>67</u> , to <u>7-30</u> , 19 <u>67</u> , that (we) last saw the deceased alive on <u>7-30</u> , 19 <u>67</u> , and that death occurred at <u>7:00 PM</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Donald W. Datlow, M.D.</u> | | 22b. DATE SIGNED
<u>7-30-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>DONALD W. DATLOW, M.D.</u> | | 22d. ADDRESS
<u>823 UNIV. BLVD. WEST SILVER SPRING, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>8-3-1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>ST. JOHNSTOWN Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>GREENWOOD DEL.</u> |
| 24. FUNERAL DIRECTOR
<u>William Flaischauer</u> | | 25a. REC'D BY REGISTRAR
<u>J. Charles Judge</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. Charles Judge</u> | | DATE
<u>AUG 3 1967</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

THEY ARE NOT IN THE HOUSE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE
HEALTH DEPT.

09808

09813

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | |
| c. LENGTH OF STAY IN 1b <u>Years</u> | | 15-1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>24 E. Montgomery Ave - Apt #2</u> | | d. STREET ADDRESS <u>24 E Montgomery Ave</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Ruby</u> First <u>H.</u> Middle <u>MANTER</u> Last | | 4. DATE OF DEATH <u>July 28</u> Month <u>1967</u> Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Feb 6 1901</u> 9. AGE (In years lost birthday) <u>66</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pathologist</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Med. St. Dept Health</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Kansas</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Walter H. Manter</u> | | 14. MOTHER'S MAIDEN NAME <u>Cora Elledge</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>217-36-2122</u> | |
| 17. INFORMANT <u>Mrs Holland Wheeler</u> Address <u>6010 Oak Street</u> | | City <u>Kansas</u> State <u>Mo.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute cardiac dilatation</u>
DUE TO (b) <u>Secondary anemia</u>
DUE TO (c) <u>Myelofibrosis of bone marrow</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> M.D. | | 22. DATE SIGNED <u>7/28/67</u> | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Bur-Transit</u> | 23b. DATE THEREOF <u>8/1/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Oak Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Laurence, Missouri</u> |
| 24. FUNERAL DIRECTOR <u>Tyson Wheeler</u> Address <u>Funeral Home-1331 Rockville Pike</u> | | 25a. RECD BY REGISTRAR <u>AUG 2 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |
| City <u>Rockville</u> State <u>Maryland</u> | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Walter J. Rector

Walter J. Rector

100-100000 - 100-100000 - 100-100000

Walter J. Rector

Walter J. Rector

Walter J. Rector

X

X

Walter J. Rector

Walter J. Rector

Walter J. Rector

Walter J. Rector

Walter J. Rector

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove all other papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|--|--|--|--|
| 09809 | | 09814 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | c. LENGTH OF STAY IN 1b <u>10 days</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u> 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u> | | d. STREET ADDRESS <u>Rt #2 Box 352</u> | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) <u>Elizabeth S Mason</u> First Middle Last | | 4. DATE OF DEATH <u>July 2</u> 19 <u>67</u> Month Day Year | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/3/02</u> 64 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) <u>64</u> yrs. |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Md. Mont. Co</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Zachariah Hawkins</u> | | 14. MOTHER'S MAIDEN NAME <u>Luzanna Stewart</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Rt 1 Gaithersburg Md -</u> Address <u>Neer Lillian New man</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c.)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Lymphosarcoma</u>
2001 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Jay R Sharpe</u> M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | 22b. DATE SIGNED |
| 22c. PHYSICIAN'S NAME (Type) <u>Jay R Sharpe</u> | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>7/6/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>BROOKE GROVE CEMETERY</u> | 23d. LOCATION (City or Town) (County) (State) <u>LAYTONSVILLE, MONTG. MD.</u> |
| 24. FUNERAL DIRECTOR <u>George R. Snowden</u> <u>Rockville Md</u> | | 25a. RECEIVED BY REGISTRAR <u>JUL 6 1967</u> 25b. REGISTERED BY <u>John J. Judge</u> | |

STATEMENT OF

20202

100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|------------------------------|---|---|--|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Mont. | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Gaithersburg | | | c. LENGTH OF STAY IN lb
2 1/2 mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Asbury Methodist Home for the Aged, Inc. | | | | | d. STREET ADDRESS
4506 Avondale St. | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print)
Martha Freme Mathieson | | | First Middle Last | | 4. DATE OF DEATH
Month July Day 27 Year 1967 | | | | | | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
April 6, 1884 | | 9. AGE (In years last birthday) yrs. 83 | | IF UNDER 1 Year
Months Days Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
housewife | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Glasgow, Scotland | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | |
| 13. FATHER'S NAME
Alexander Freme | | | | | 14. MOTHER'S MAIDEN NAME
Annie Brown | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | | 16. SOCIAL SECURITY NO.
579-03-3882D | | 17. INFORMANT Address
Asbury Methodist Home, Gaithersburg, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
332x IMMEDIATE CAUSE (a) Cerebral Thrombosis
DUE TO (b) Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Parkinson's Disease | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
9 DAYS
20 YRS. | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 5/16/67 , 19 to 7/27/67 19, that (I) (we) saw the deceased alive on 7/26/67 19, and that death occurred at 7:50 A.M. from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Henry C. Scruggs M.D. | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
7/27/67 | | | | |
| 22c. PHYSICIAN'S NAME (Type) HENRY C. SCRUGGS, M.D. | | | | | 22d. ADDRESS
&&" 7720 Wisconsin Ave., Bethesda | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF
July 29, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
ROCK CREEK CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
Washington, D.C. | | | | | |
| 24a. REC'D BY REGISTRAR
ROBERT A. PUMPHREY ADDRESS BETHESDA, MARYLAND | | | | | 24b. REGISTRAR'S SIGNATURE
AUG 1 1967 | | 24c. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

1908

LIST OF PLANTS

1. *Abies balsamea* (Mill.) (B.S.P.)

2. *Abies balsamea* (Mill.) (B.S.P.)

3. *Abies balsamea* (Mill.) (B.S.P.)

4. *Abies balsamea* (Mill.) (B.S.P.)

5. *Abies balsamea* (Mill.) (B.S.P.)

6. *Abies balsamea* (Mill.) (B.S.P.)

7. *Abies balsamea* (Mill.) (B.S.P.)

8. *Abies balsamea* (Mill.) (B.S.P.)

9. *Abies balsamea* (Mill.) (B.S.P.)

10. *Abies balsamea* (Mill.) (B.S.P.)

11. *Abies balsamea* (Mill.) (B.S.P.)

12. *Abies balsamea* (Mill.) (B.S.P.)

13. *Abies balsamea* (Mill.) (B.S.P.)

14. *Abies balsamea* (Mill.) (B.S.P.)

15. *Abies balsamea* (Mill.) (B.S.P.)

16. *Abies balsamea* (Mill.) (B.S.P.)

17. *Abies balsamea* (Mill.) (B.S.P.)

18. *Abies balsamea* (Mill.) (B.S.P.)

19. *Abies balsamea* (Mill.) (B.S.P.)

20. *Abies balsamea* (Mill.) (B.S.P.)

21. *Abies balsamea* (Mill.) (B.S.P.)

22. *Abies balsamea* (Mill.) (B.S.P.)

23. *Abies balsamea* (Mill.) (B.S.P.)

24. *Abies balsamea* (Mill.) (B.S.P.)

25. *Abies balsamea* (Mill.) (B.S.P.)

26. *Abies balsamea* (Mill.) (B.S.P.)

27. *Abies balsamea* (Mill.) (B.S.P.)

28. *Abies balsamea* (Mill.) (B.S.P.)

29. *Abies balsamea* (Mill.) (B.S.P.)

30. *Abies balsamea* (Mill.) (B.S.P.)

31. *Abies balsamea* (Mill.) (B.S.P.)

32. *Abies balsamea* (Mill.) (B.S.P.)

09811

CERTIFICATE OF DEATH

09816

| | | | | | |
|--|----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY
MONTGOMERY
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN lb
5 yrs. | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
MARYLAND
b. COUNTY
MONTGOMERY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
6048 Avon Dr., | | | | d. STREET ADDRESS
6048 Avon Dr., | |
| 3. NAME OF DECEASED
(Type or print)
JOHN J. McDONALD | | | 4. DATE OF DEATH
Month JULY Day 22 Year 19 67 | | |
| 5. SEX
MALE | 6. COLOR OR RACE
WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Aug. 26, 1915 | | 9. AGE (In years last birthday) yrs. 51 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Carpenter | | 10b. KIND OF BUSINESS OR INDUSTRY
Building | | 11. BIRTHPLACE (County & State, or foreign country)
Billings, Montana | |
| 13. FATHER'S NAME
JOSEPH W. McDONALD | | | 14. MOTHER'S MAIDEN NAME
AGNES G. GILSKEY | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
578-30-5149 | | 17. INFORMANT Brother -8126 Old Georgetown Rd.
DONALD S. McDONALD (Bethesda, Md.) | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia
1810 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Lung
DUE TO (c) Carcinoma of Urinary Bladder | | | | | INTERVAL BETWEEN ONSET AND DEATH
2 mos. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from 5-9- , 19 67 , to 7-22- , 19 67 , that (I) (we) last saw the deceased alive on 7-22- 1967, and that death occurred at 11:45 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Ronald Barr | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
7-23-67 | |
| 22c. PHYSICIAN'S NAME (Type)
DR. RONALD BARR | | 22d. ADDRESS
10401 Old Georgetown Rd., Bethesda | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 25, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | |
| 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | 24. FUNERAL DIRECTOR
ROBERT A. PUMPHREY BETHESDA, MD. | | | |
| 25a. REC'D BY REGISTRAR
JUL 25 1967 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09812

09817

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH
o. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
o. STATE Md b. COUNTY Pro Geo | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Tokoma Park, Md | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
College Park, Md. | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Wash Sanitarium and Hospital | | d. STREET ADDRESS
5901 Natasha Drive | |
| 3. NAME OF DECEASED
(Type or print) Jessie N McKoy | | 4. DATE OF DEATH
Month July Day 12 Year 19 67 | |
| 5. SEX
male | 6. COLOR OR RACE
white | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec 4, 1892 |
| 9. AGE (In years last birthday) yrs. 74 | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer | | 10b. KIND OF BUSINESS OR INDUSTRY
Farming | |
| 11. BIRTHPLACE (County & State, or foreign country)
North Carolina | | 12. CITIZEN OF WHAT COUNTRY?
U S A | |
| 13. FATHER'S NAME
Luke W McKoy | | 14. MOTHER'S MAIDEN NAME
Annie L Taylor | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
240 26 6737 | |
| 17. INFORMANT
Linwood W McKoy | | Address
Beltsville, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Liver Failure
5810
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Cirrhosis; Cholangitis
DUE TO
(c) Intrahepatic Biliary Stasis | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Gastric ulcers, Hemorrhagic | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 4/30 , 19 67 , to 7/12 , 19 67 , that (I) (we) last saw the deceased alive on 7/12 , 19 67 , and that death occurred at _____ M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Joseph E. Smith Jr. | | 22b. DATE SIGNED
7/13/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Joseph E. Smith, Jr. M.D. | | 22d. ADDRESS
Beltsville, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
July 15, 1967 | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln Cemetery | 23d. LOCATION (City or Town) (County) (State)
Colmar Manor Pro Geo Md. |
| 24. FUNERAL DIRECTOR
F Gasch's Sons | | 25a. REC'D BY REGISTRAR
JUL 17 1967 | |
| ADDRESS
Hyattsville, Md. | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

1

207-2

DEPARTMENT OF HEALTH

THE GAS

IN

CONCENTRATION

COLLEGE PARK, MD.

1940-1941

DEPT. OF HEALTH

DEPT. OF HEALTH

UNIT 1

UNIT 2

UNIT 3

UNIT 4

UNIT 5

UNIT 6

UNIT 7

UNIT 8

UNIT 9

UNIT 10

UNIT 11

UNIT 12

UNIT 13

UNIT 14

UNIT 15

UNIT 16

UNIT 17

UNIT 18

UNIT 19

UNIT 20

UNIT 21

UNIT 22

UNIT 23

UNIT 24

UNIT 25

UNIT 26

UNIT 27

UNIT 28

UNIT 29

UNIT 30

UNIT 31

UNIT 32

UNIT 33

UNIT 34

UNIT 35

UNIT 36

UNIT 37

UNIT 38

UNIT 39

UNIT 40

UNIT 41

UNIT 42

UNIT 43

UNIT 44

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09813

09813

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any information is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY
Montgomery | | b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | c. LENGTH OF STAY IN lb
15 min. | | 2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE
Maryland | | b. COUNTY
Montgomery | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring Wheaton | | d. STREET ADDRESS
11722 Grandview Avenue | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Ross Taylor | | First
Ross | | Middle
Taylor | | Last
Medeiros | | DATE OF DEATH
Month
7 | | Day
30 | | Year
1967 | | | |
| 5. SEX
Male | | 6. COLOR OR RACE
Cauc. | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
9-5-63 | | 9. AGE (In years last birthday)
4 3 yrs. | | IF UNDER 1 YEAR
Months
7 | | Days
30 | | IF UNDER 24 HRS.
Hours
15 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
None | | 10b. KIND OF BUSINESS OR INDUSTRY
None | | 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME
Frank Medeiros | | 14. MOTHER'S MAIDEN NAME
Joan Luckett | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
No | | 16. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Frank Medeiros | | Address
11722 Grandview Avenue Silver Spring, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Respiratory failure | | | | | | | | | | | | | | | |
| 9020 DUE TO | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Dislocation of neck between C₁ and C₂ 40 min. | | | | | | | | | | | | | | | |
| (c) Fall and hitting chin 40 min. | | | | | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None | | | | | | | | | | | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Fell 10 ft. off a porch | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour e.m.
3:00 p.m. 7/30/67 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Home | | 20f. (City or town)
Silver Spring, Mont., Md. | | (County) | | (State) | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
John S. Rogers, M.D. | | EXAMINER'S NAME (Type)
1919 Seminary Rd., Sil. Srp., Md. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED
7/30/67 | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
August 2, 1967 | | 22c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Cemetery | | 22d. LOCATION (City, town, or county)
Prince Georges Co., Maryland | | (State) | | | | | | | |
| 23. FUNERAL DIRECTOR
Glenn Carter | | ADDRESS
8434 Georgia Avenue | | 24a. REC'D BY REGISTRAR
Warner E. Pumphrey, Inc. | | 24b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
AUG 1 1967 | | | | | | | |

THE STATE OF TEXAS,
COUNTY OF DALLAS.I, the undersigned, a Notary Public in and for the State of Texas, do hereby certify that the within and foregoing is a true and correct copy of the original of the same, as the same appears from the records of the County of Dallas, State of Texas, in and to which said original is duly filed for record.
IN WITNESS WHEREOF, I have hereunto set my hand and the seal of said County, at the City of Dallas, this 1st day of August, 1987.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09814

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09819

| | | | |
|---|------------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> | | c. LENGTH OF STAY IN 1b <u>5 yrs</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4312 Frankfort Dr.</u> | | d. STREET ADDRESS <u>4312 Frankfort Dr.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>ALLAN LEONARD MENDELSON</u> | | 4. DATE OF DEATH <u>July 19 1967</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Cauc</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 9, 1932</u> |
| 9. AGE (In years last birthday) <u>34</u> yrs. | | 10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ATTORNEY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>LEGAL</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>WASH. D.C.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>BENJAMIN L. MENDELSON</u> | | 14. MOTHER'S MAIDEN NAME <u>TESS WEITZ</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>578-42-4426</u> | |
| 17. INFORMANT <u>FATHER</u> | | Address <u>9039 Sligo Creek Pkwy Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Gunshot wound through head, apparently self-inflicted.</u>
DUE TO (b) <u> </u>
DUE TO (c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u> </u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Deceased, depressed, shot self in head with automatic pistol.</u> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u> </u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>5:45 p.m. 7-19-1967</u> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u> | |
| 20e. (City or town) <u>Rockville</u> | | 20f. (County) <u>Montgomery</u> | |
| 20g. (State) <u>Md</u> | | 20h. (City or town) <u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Underdetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Belden R. Reap</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22. DATE SIGNED <u>7-19-1967</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>7/21/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>King David Memorial Garden</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Falls Church, Virginia</u> | |
| 24. FUNERAL HOME <u>M. Stein Hebrew Memorial Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>JUL 24 1967</u> | |
| ADDRESS <u>232 Carroll St. N.W. Washington, D.C.</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

1

RECEIVED
JUL 1 1963
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

| Item 19 11m 390 7-20-67 MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | |
|--|--|------------------------------------|--|---|--|--|---|---|---|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
| 09815 | | | | | CERTIFICATE OF DEATH | | | | | 09820 | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>King George</u> | | | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>RURAL Bethesda</u> | | | | | c. LENGTH OF STAY IN Tb
<u>7 days</u> | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>King George</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Naval Hospital, Bethesda, Md.</u> | | | | | d. STREET ADDRESS
<u>Box 77</u> | | | | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>John Albert MEROTH</u> | | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>2</u> Year <u>1967</u> | | | | | | | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>Cauc</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>6 Jul 1911</u> | | 9. AGE (In years last birthday)
<u>55</u> yrs. | | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>U.S. ARMY (retired)</u> | | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u> </u> | | | | | 11. BIRTHPLACE (County & State, or foreign country)
<u>New Haven, Conn.</u> | | | | |
| 13. FATHER'S NAME
<u>Albert MEROTH</u> | | | | | 14. MOTHER'S MAIDEN NAME
<u>Helen HANSMAN</u> | | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)
<u>Yes 10-2-42 to 1-30-63</u> | | | | | 16. SOCIAL SECURITY NO.
<u>045 03 8800</u> | | | | | 17. INFORMANT
<u>Mrs. Simone M. MEROTH</u> | | | | |
| | | | | | Address <u>Box 77</u> | | | | | <u>King George, Va.</u> | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinoma, right lung with Metastasis</u>
DUE TO <u>163X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u> </u>
DUE TO <u> </u>
(c) <u> </u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. <u> </u> p.m. <u>19</u> | | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | | | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>26 Jun</u> , 19 <u>67</u> , to <u>2 Jul</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2 Jul</u> , 19 <u>67</u> , and that death occurred at <u>5:53A</u> M, from causes and on the date stated above. | | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>W. J. Foote</u> | | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | | | 22b. DATE SIGNED
<u> </u> | | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>W. J. FOOTE, CDR MC USN</u> | | | | | 22d. ADDRESS
<u>Naval Hospital, Bethesda, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>CREMATION</u> | | 23b. DATE THEREOF
<u>7-3-67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>CEDAR HILL CREMATORY</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland Md.</u> | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>IVES FUNERAL HOME, ARLINGTON, VA.</u> | | | | | 25a. REGISTRY REGISTRAR
<u>JUL 6 1967</u> | | | | | 25b. REGISTRAR'S SIGNATURE
<u>James C. Dwyer</u> | | | | |

098816

CERTIFICATE OF DEATH

098821

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> | | c. LENGTH OF STAY IN lb
<u>15.1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Holy Cross Hospital</u> | | d. STREET ADDRESS
<u>Rt 3 Box 178</u> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Thomas</u> Middle <u>Michael</u> Last <u>Miller</u> | | 4. DATE OF DEATH
Month <u>July</u> Day <u>11</u> Year <u>1967</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 10, 1967</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Infant</u> | 9. AGE (In years last birthday) yrs. <u>2</u> IF UNDER 1 YEAR Months Days Hours Min. |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Maryland - Montgomery Co</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>John Murren Miller</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margie Ellen Darner</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>-----</u> | 17. INFORMANT
<u>Father</u> Address |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<u>776X</u> IMMEDIATE CAUSE (a) <u>Prematurity</u>
DUE TO (b) <u>41 hrs.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1967</u> to <u>July 11, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 11, 1967</u> , and that death occurred at <u>5:15 P.M.</u> from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Ralph Stiller</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Ralph Stiller M.D.</u> | | 22d. ADDRESS
<u>1111 Spring Street S.S.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>7/21/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Md.</u> |
| 24. FUNERAL DIRECTOR
<u>Tyson Wheeler Funeral Home</u> | | 25a. REC'D BY REGISTRAR
<u>Rockville, Md.</u> | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

CERTIFICATE OF DEATH

09817

09822

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>47 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> 151 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Md. 20014</u> | | | | d. STREET ADDRESS
<u>7502 Alfred Drive</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Salvatore (NMN) Millone</u> | | | | 4. DATE OF DEATH Month Day Year
<u>July 5 19 67</u> | | | |
| 5. SEX
<u>Male</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 19, 1915</u> | |
| 9. AGE (In years last birthday) yrs.
<u>52</u> | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Tile Setter</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Tile</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Italy</u> | |
| 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | | 13. FATHER'S NAME
<u>Stefano Millone</u> | | | |
| 14. MOTHER'S MAIDEN NAME
<u>Leonarda Rapisardi</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | | |
| 16. SOCIAL SECURITY NO.
<u>214-34-6828</u> | | | | 17. INFORMANT <u>The Medical Record</u>
<u>The Clinical Center, Bethesda, Md. 20014</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Bronchopneumonia and purulent meningitis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Metastatic carcinoma of the lung</u>
DUE TO
(c) _____
INTERVAL BETWEEN ONSET AND DEATH
<u>4 days</u>
<u>4 months</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Urinary tract infection</u> | | | | | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 19</u> , 19 <u>67</u> , to <u>July 5</u> , 19 <u>67</u> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>July 5</u> , 19 <u>67</u> , and that death occurred at <u>6:25</u> M, from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>CM Haskell</u> | | | | M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> A | | 22b. DATE SIGNED
<u>5 July 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Charles M. Haskell, MD</u> | | | | 22d. ADDRESS
<u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>7 JULY 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>CATHOLIC HEAVEN</u> | | 23d. LOCATION (City or town) (County) (State)
<u>SILVER SPRING MD.</u> | |
| 24. FUNERAL DIRECTOR
<u>Rinaldi FUNERAL HOME, INC. 7400 GEORGIA AVE. N.W.</u> | | | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF TEXAS

1900

County of _____

City of _____

State of _____

County of _____

Know all men by these presents, that _____ of the County of _____ State of _____ do hereby certify that _____ of the County of _____ State of _____ is the owner of the following described land to-wit:

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

09818

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09823

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Gaithersburg</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>11 Chestnut Street</u> | | d. STREET ADDRESS
<u>11 Chestnut Street</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Nettie</u> | | 4. DATE OF DEATH
Month <u>July</u> - Day <u>14</u> - Year <u>1967</u> | |
| 5. SEX
<u>Fe</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec 15, 1892</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>H</u> | 9. AGE (In years lost birthday) <u>74</u> yrs. |
| 11. BIRTHPLACE (State or foreign country)
<u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Bradley Norwood</u> | | 14. MOTHER'S MAIDEN NAME
<u>Margaret Trail</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>577-32-7420</u> | |
| 17. INFORMANT
<u>Thomas Norwood</u> | | Address <u>1018 Scott Ave Rockville, Md</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Insufficiency Acute</u>
2044
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Chronic Leukemia</u>
(c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>Years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. _____ p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John G. Ball</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>John G. Ball</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>7/15/67</u> | |
| | | Address (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF
<u>7-17-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Parklawn</u> | 23d. LOCATION (City or town) (County) (State)
<u>Rockville Montg. Md.</u> |
| 24. FUNERAL DIRECTOR <u>Ernest C. Gartner</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 19 1967</u> | |
| Address <u>Gaithersburg, Md.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | |

MEMORANDUM FOR THE RECORD

DATE: 10/10/50

TO: THE SECRETARY OF THE ARMY

FROM: THE CHIEF OF STAFF

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

25. [Illegible]

26. [Illegible]

27. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09819

09824

| | | | |
|---|------------------------------|---|------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>North Chevy Chase</u> | | c. LENGTH OF STAY IN 1b
<u>15-1</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS
<u>3807 Inverness Drive</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Sylvia</u> First <u>Stevens</u> Middle <u>Moore</u> Last | | 4. DATE OF DEATH
Month <u>July</u> Day <u>23</u> Year <u>1967</u> | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9-25-05</u> |
| 9. AGE (In years last birthday)
<u>61</u> yrs. | | IF UNDER 1 YEAR
Months <u>23</u> Days <u>19</u> Hours <u>67</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Chicago Ill</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Robert W. Stevens</u> | | 14. MOTHER'S MAIDEN NAME
<u>Lillian Brown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
<u>Husband of 3807 Inverness Dr.</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial failure</u>
DUE TO
(b) <u>Emphysema</u>
DUE TO
(c) <u>5271</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Schizophrenia</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<u>-</u> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)
<u>None</u> | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>-</u> , 19 <u>66</u> , to <u>present</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/21</u> 19 <u>67</u> , and that death occurred at <u>8:00 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John B. Umhau</u> | | 22b. DATE SIGNED
<u>7/23/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>JOHN B. UMHAN</u> | | 22d. ADDRESS
<u>8805 CONN. AVE CHEVY CHASE</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Cremation</u> | | 23b. DATE THEREOF
<u>7-24-67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Crematory</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Suitland, Maryland</u> | |
| 24. FUNERAL DIRECTOR
<u>ROBERT A. PUMPHREY, Bethesda, Maryland</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 25 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

RECEIVED

DEPARTMENT OF HEALTH

1918

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

[Faint, illegible handwritten text at the bottom of the page, likely bleed-through.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
|---|--|---|---|
| CERTIFICATE OF DEATH | | | |
| 09820 | | 09825 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> | |
| c. LENGTH OF STAY IN 1b <u>27 days</u> | | d. STREET ADDRESS <u>5509 Sonoma Road</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Ludman</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Clifford L. Morrison</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>6</u> Year <u>1967</u> | |
| 5. SEX <u>m.</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-6-96</u> |
| 9. AGE (In years lost birthday) <u>71</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bank Teller</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>James L.</u> | | 14. MOTHER'S MAIDEN NAME <u>Annie E. Bogley</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>220-28-5805</u> | |
| 17. INFORMANT <u>Elizabeth M. Umbholtz</u> | | Address <u>2308 E. Bonaville Silver Spring</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
DUE TO <u>Chronic G.U. Tract Infection</u>
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. (b) <u>1954</u>
(c) | | INTERVAL BETWEEN ONSET AND DEATH <u>5/22/67</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/6</u> , 19 <u>67</u> , to <u>7/6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/6</u> , 19 <u>67</u> , and that death occurred at <u>10 p.m.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Clifford L. Morrison</u> | | 22b. DATE SIGNED <u>7/6/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>A. J. Brennan</u> | | 22d. ADDRESS <u>Chevy Chase Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL <u>Burial</u> | 23b. DATE THEREOF <u>7-10-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Rockville Maryland</u> |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> | | 25a. REC'D BY REGISTRAR <u>JUL 10 1967</u> | |
| ADDRESS <u>7557 Wisconsin Ave Bethesda, Md</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

1000

OFFICE OF THE

The undersigned
 do hereby certify that
 the within and foregoing
 is a true and correct
 copy of the original
 as the same appears
 from the records
 of the office of the
 Secretary of the
 State of New York
 this 10th day of
 January 1900

Signed in presence of
 Notary Public
 State of New York
 1000

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

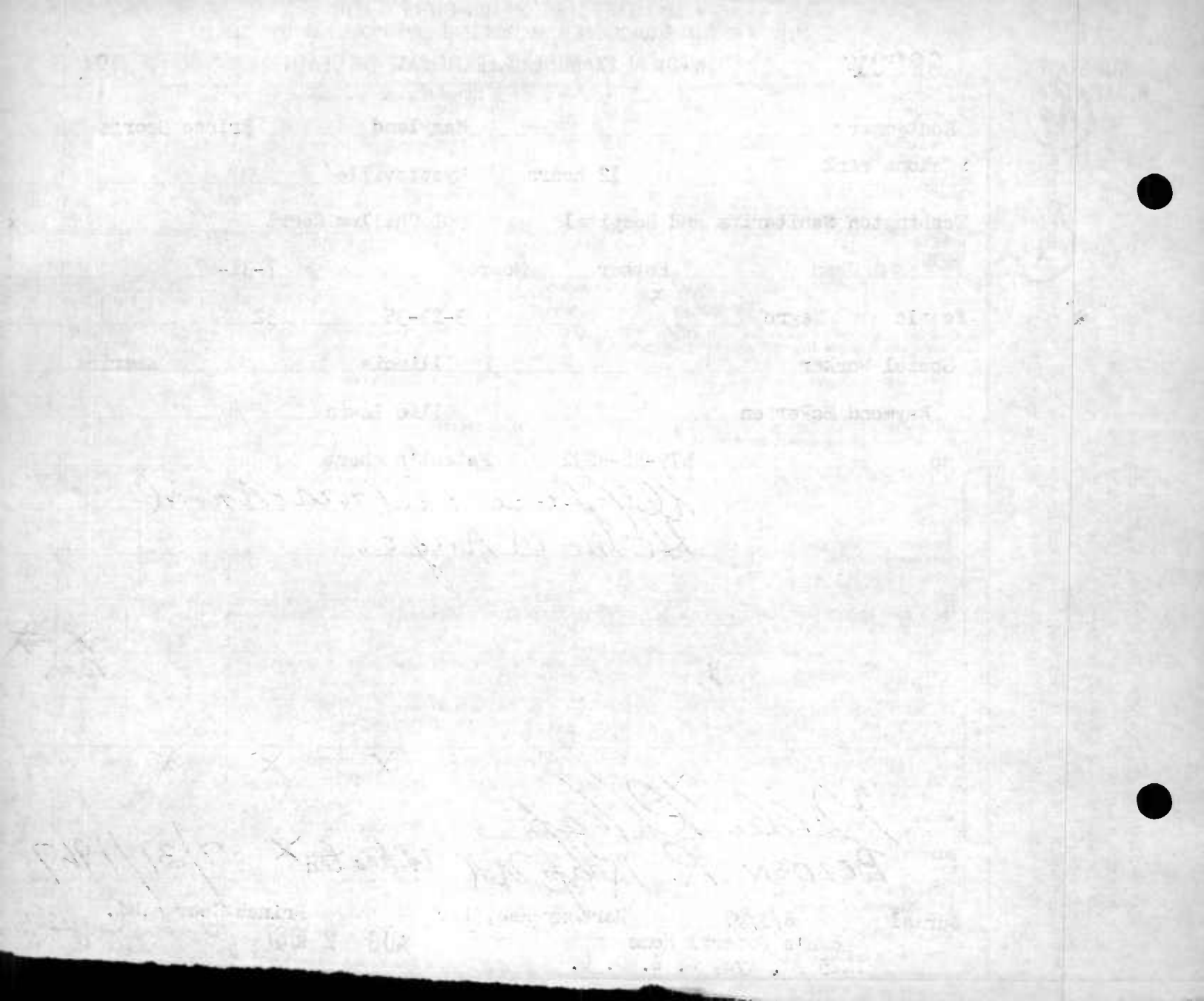
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09821

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09826

| | | | | | | | |
|---|----------------------------------|---|------------------------------------|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park | | c. LENGTH OF STAY IN 1b
12 hours | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hyattsville | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium and Hospital | | | | d. STREET ADDRESS
901 Chillum Court | | | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
Jean Esther Mowrey | | | | 4. DATE OF DEATH
Month Day Year
7-31-67 19 | | | |
| 5. SEX
female | 6. COLOR OR RACE
Negro | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-23-35 | | 9. AGE (In years last birthday)
32 yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Social Worker | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
Illinois | | 12. CITIZEN OF WHAT COUNTRY?
America | |
| 13. FATHER'S NAME
Raymond McFerren | | | | 14. MOTHER'S MAIDEN NAME
Ollie Lewis | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
579-48-4232 | | 17. INFORMANT
Patent's chart Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
330 X IMMEDIATE CAUSE (a) Diffuse Subarachnoid Hemorrhage.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
BAR |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Belden R. Reap | | EXAMINER'S NAME (Type)
BELDEN R. Reap M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
Address (Street, city, town, or county) | | 22. DATE SIGNED
7/31/1967 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
8/3/67 | | 23c. NAME OF CEMETERY OR CREMATORY
Harmony Meo, Park | | 23d. LOCATION (City or town) (County) (State)
Prince George, Md. | |
| 24. FUNERAL DIRECTOR
Lowe's Funeral Home
1425 Md. Ave. N. E. D. C. | | | | 25. AUG 2 1967
DATE | | 25. John J. [Signature]
REGISTERED SIGNATURE | |



09822

CERTIFICATE OF DEATH

09827

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Fairland - Rural | | c. LENGTH OF STAY IN lb
Silver Spring | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Fairland Nursing Home | | d. STREET ADDRESS
801 Seeks Lane | |
| 3. NAME OF DECEASED (Type or print) TERESA First Middle Last | | 4. DATE OF DEATH July 4, 1967 Month Day Year | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH March 7, 1882 |
| 9. AGE (In years last birthday) 85 yrs. | | 10. IF UNDER 1 YEAR 19 Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Henry Schultz | | 14. MOTHER'S MAIDEN NAME
Catherine Dean | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 220-48-0968 | |
| 17. INFORMANT F. Dean Mullican-Item # 2 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
0531 Staphylococcal Septicemia
IMMEDIATE CAUSE (a) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Generalized arteriosclerosis | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from 11/30 , 19 65 , to 7/4 , 19 67 that (I) (we) last saw the deceased alive on 7/4 , 19 67 , and that death occurred at 2:45 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE Norman H. Rubenstein | | 22b. DATE SIGNED 7/4/67 | |
| 22c. PHYSICIAN'S NAME (Type) Norman H. Rubenstein | | 22d. ADDRESS 359 Scott Dr., Silver Spring, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 7/6/67 | 23c. NAME OF CEMETERY OR CREMATORY Colesville Meth. Ch. Cem. | 23d. LOCATION (City or Town) (County) (State) Colesville, Md. |
| 24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike | | 25a. REC'D BY REGISTRAR JUL 7 1967 | |
| ADDRESS Rockville, Md. | | 25b. REGISTRAR'S SIGNATURE Charles J. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09823

CERTIFICATE OF DEATH

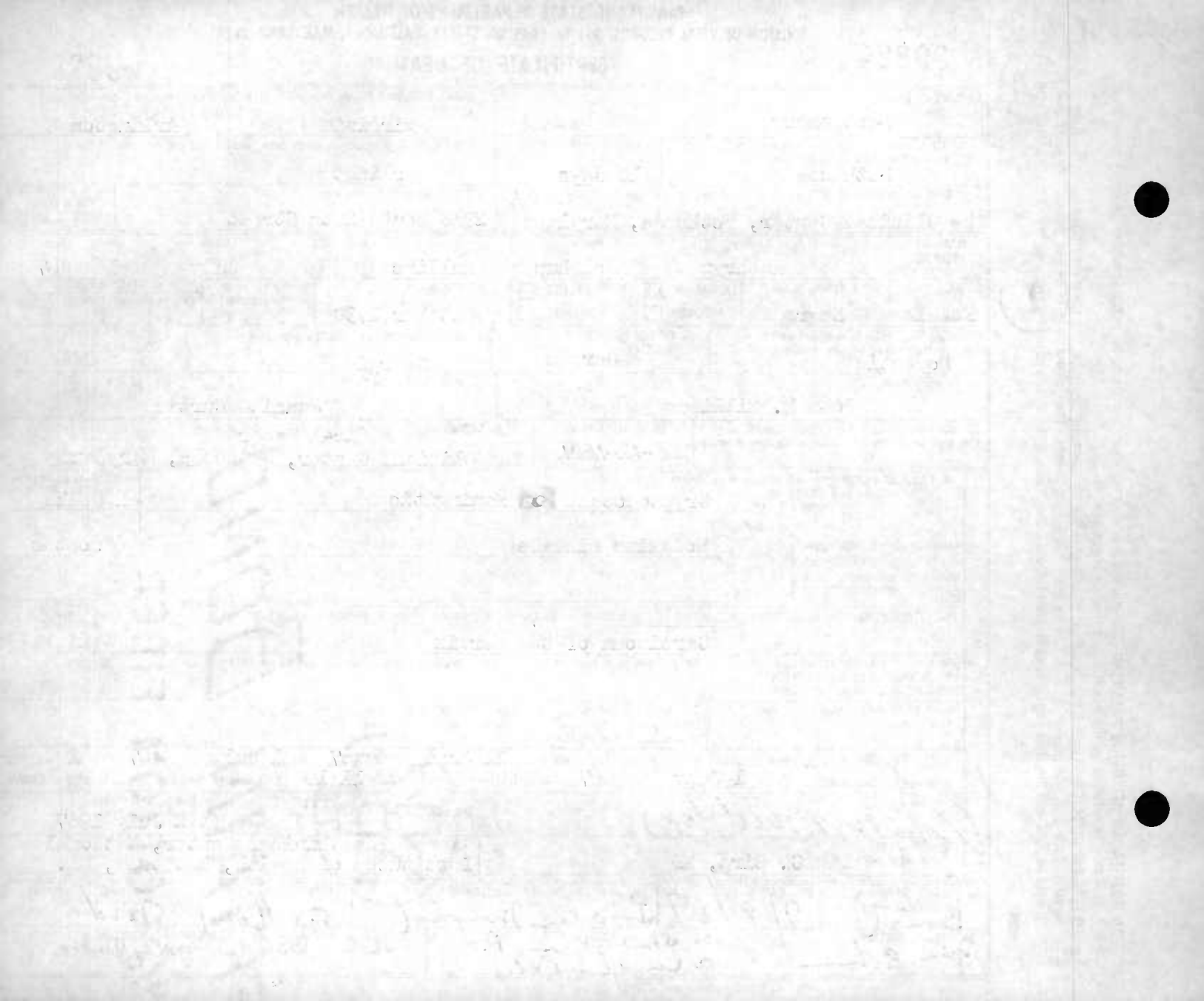
09823

| | | | | | |
|--|----------------------------------|--|---|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural- Lewisdale | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Rural- Lewisdale | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
RFD, Monrovia | | | d. STREET ADDRESS
R.F.D. Monrovia | | e. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print) Urner R. Mullinix | | | 4. DATE OF DEATH
Month July Day 29 Year 19 67 | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
June 7, 1890 | | 9. AGE (In years last birthday)
77 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Brick layer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country)
Lewisdale, Md. | |
| 13. FATHER'S NAME
Sherman Mullinix | | | 14. MOTHER'S MAIDEN NAME
Annie D. Mullinix | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) Yes (If yes give war or dates of service) W.W. 1 | | 16. SOCIAL SECURITY NO.
214-14-4378 | | 17. INFORMANT
Mrs E. Rena Mullinix, Item 2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the Lung
163X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) DUE TO
(c) DUE TO | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 year ? |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Arteriosclerotic Cardiovascular Renal Disease | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
No accident involved | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from April 5, 19 67 to July 29, 19 67 , that (I) (we) saw the deceased alive on July 29, 19 67 , and that death occurred at 6:00 AM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>[Signature]</i> | | 22b. DATE SIGNED
July 30, 1967 | | 22c. PHYSICIAN'S NAME (Type)
M. McKendree Boyer, M.D. | |
| 22d. ADDRESS
9701 Church Street
Damascus, Maryland. | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | |
| 23b. DATE THEREOF
July 31, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Bethesda Meth. | | 23d. LOCATION (City or Town) (County) (State)
Brownsville, Md. | |
| 24. FUNERAL DIRECTOR
Olin L. Molesworth, Damascus, Md. | | 25a. REC'D BY REGISTRAR
AUG 1 1967 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|----------------------------------|--|---|---|--|--|--|---------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 09824 | | | | | | | | | |
| 09829 | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>Arlington</u> | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | | c. LENGTH OF STAY IN 1b
<u>10 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Arlington</u> <u>P33</u> | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>The Clinical Center, Bethesda, Maryland</u> | | | | | d. STREET ADDRESS
<u>2918 South 20th Street</u> | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED
(Type or print)
First <u>Kathryn</u> Middle <u>Adolphus</u> Last <u>Mullins</u> | | | | | 4. DATE OF DEATH
Month <u>July</u> Day <u>1</u> Year <u>1967</u> | | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | B. DATE OF BIRTH
<u>9 October 1930</u> | 9. AGE (In years lost birthday) yrs.
<u>36</u> | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Service</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>Georgia</u> | | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | |
| 13. FATHER'S NAME
<u>John B. Williams</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Juanita Curtis</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>228-42-4604</u> | | 17. INFORMANT
<u>The Medical Record</u> Address
<u>The Clinical Center, Bethesda, Maryland</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cryptococcal Meningitis</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Hodgkins Disease</u>
DUE TO
(c) <u> </u>
INTERVAL BETWEEN ONSET AND DEATH
<u>2 weeks</u>
<u>6 months</u> | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Carcinoma of the cervix</u> | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u> </u> a.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>21 June</u> , 19 <u>67</u> , to <u>1 July</u> , 19 <u>67</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>1 July</u> , 19 <u>67</u> , and that death occurred at <u>11:10M</u> , from causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
<u>Dan C. Bird</u> | | | | 22b. DATE SIGNED
M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>2 July 1967</u> | | | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>Dan C. Bird, MD</u> | | | | 22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/8/67</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Lincoln Memorial</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>South Arlington, Md.</u> | | | |
| 24. FUNERAL DIRECTOR
<u>J. A. Bird</u> | | | | 25a. RECEIVED BY REGISTRAR
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | DATE
<u>JUL 8 1967</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09825

CERTIFICATE OF DEATH

09830

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE DC b. COUNTY 473 | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
SILVER SPRING | | c. LENGTH OF STAY IN lb
Approx 3 Mo. | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Washington | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
SYLVAN MAJOR HEALTH CARE CENTER | | | | d. STREET ADDRESS
4600 - 45th ST NW | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First FRANCES Middle E. Last MURPHY | | | | 4. DATE OF DEATH
Month JULY Day 9 Year 1967 | | | |
| 5. SEX FEMALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
APR. 12 1876 91 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
- | | 11. BIRTHPLACE (County & State, or foreign country)
KANSAS | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME
Hallgrave | | | | 14. MOTHER'S MAIDEN NAME
TERESA ? | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | | 16. SOCIAL SECURITY NO.
NONE | | 17. INFORMANT
LAURENCE SPELLBRING DICKERSON, MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
332X IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO (b) Arteriosclerosis
DUE TO (c) - | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
3 da. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19
p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Jul 3, 1967 , to Jul 9, 1967 , that (I) (we) last saw the deceased alive on Jul 8, 1967 , and that death occurred at 9:30 AM from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
Robert T. Thibadeau | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
7-9-67 | |
| 22c. PHYSICIAN'S NAME (Type)
ROBERT T. THIBADEAU | | | | 22d. ADDRESS
ROCKVILLE MD 20852 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
JULY 12 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
MT. OLIVET CEM. | | 23d. LOCATION (City or Town) (County) (State)
WASHINGTON, D.C. | |
| 24. FUNERAL DIRECTOR
H. Dow. DeVol | | | | ADDRESS
DC | | 25a. REC'D BY REGISTRAR
JUL 12 1967 | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

CERTIFICATE OF DEATH

DECEASED
NAME
DATE OF BIRTH
PLACE OF BIRTH

SEX

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Nurse

Signature of Chaplain

Signature of Minister

Signature of Undertaker

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

VR A15 (4)
25M 1/67

BP

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|---------------------------------------|--|--|--|--|--|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>WASHINGTON D.C.</u> b. COUNTY <u>47-3</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>CHERRY CHASE</u> | | | | c. LENGTH OF STAY IN 1b
<u>9 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>7045 3rd ST. N.W.</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>BETHESDA SILVER SPRING NURSING HOME</u> | | | | | | d. STREET ADDRESS
<u>7045 3rd ST. N.W.</u> | | | | | |
| 3. NAME OF DECEASED
(Type or print) <u>CHARLES ELMER MURRAY SR.</u> | | | | | | 4. DATE OF DEATH
Month <u>7</u> Day <u>21</u> Year <u>1967</u> | | | | | |
| 5. SEX
<u>MALE</u> | | 6. COLOR OR RACE
<u>CAUC.</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>1/27/1896</u> | | 9. AGE (In years last birthday)
<u>71</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>RETIRED</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>PRINTING BUSINESS</u> | | 11. BIRTHPLACE (County & State, or foreign country)
<u>WASHINGTON DC</u> | | | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>WILLIAM MURRAY</u> | | | | | | 14. MOTHER'S MAIDEN NAME
<u>BERTHA KELLY</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>1ST COAST GUARD</u> | | | | 16. SOCIAL SECURITY NO.
<u>577-10-1898-A</u> | | 17. INFORMANT
<u>Gertrude C. Murray</u>
Address <u>WIFE - See Item #2-</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO <u>ASHD.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Genl. arteriosclerosis</u>
DUE TO (c) <u>Genl. arteriosclerosis</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>30 minutes</u>
<u>5 yrs.</u>
<u>5-7 yrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Pt had massive stroke mid June 1967.</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>present</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>19 July 1967</u> , and that death occurred at <u>2 P</u> M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Charles E. Keegan Jr</u> | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
<u>21 July 1967.</u> | | | |
| 22c. PHYSICIAN'S NAME (Type)
<u>CHARLES E. KEEGAN JR. MD</u> | | | | | | 22d. ADDRESS
<u>3752 Benton St NW WASH DC 20007.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7-25-1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery, Silver Spring, Md.</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>WASH DC</u> | | | |
| 24. FUNERAL DIRECTOR
<u>Joseph GAWKORSKI, SOUTHWEST CORNERS</u> | | | | ADDRESS
<u>3130 WISCONSIN AVE WASH. D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 25 1967</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

09826

09831

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

1914

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

CERTIFICATE OF DEATH

09827

09832

| | | | |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Mont.</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING, MD.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>ROCKVILLE, MARYLAND</u> | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS
<u>259 Congressional Ave</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>NELLIE</u> Middle <u>BEST</u> Last <u>NEFF</u> | | 4. DATE OF DEATH
Month <u>JULY</u> Day <u>19</u> Year <u>1967</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>AUG. 23, 1889</u> |
| 9. AGE (In years last birthday)
<u>77</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u>10</u> Days <u>26</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>HUTCHINSON, KANSAS</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>RICHARD E. ROBERTS</u> | | 14. MOTHER'S MAIDEN NAME
<u>Ellen Best Roberts</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO.
<u>267461729B</u> | |
| 17. INFORMANT
<u>Harold A. Neff-259 Congressional Lane</u> | | Address
<u>Rockville, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4200</u> IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u>
DUE TO (b) <u>ARTERIO SCLEROTIC HEART DISEASE</u>
DUE TO (c) <u>10 YRS.</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>Cerebrovascular Disease with Vascular occlusion</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>o.m.</u> <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>July 10, 1965</u> to <u>July 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>7/18</u> 19 <u>67</u> , and that death occurred at <u>9:25 PM</u> on <u>7/20/67</u> at <u>the date stated above</u> . | | | |
| 22a. SIGNATURE
<u>Max G. Sherer</u> | | 22b. DATE SIGNED
<u>7/20/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>MAX G. SHERER MD</u> | | 22d. ADDRESS
<u>800 Pershing Drive S.E. Sp. Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE THEREOF
<u>7/22/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<u>Ft. Lincoln Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Prince Georges Co. Md.</u> | |
| 24. FUNERAL DIRECTOR
<u>Thos. H. Neim Co. Wash. D.C.</u> | | 25a. REC'D BY REGISTRAR
<u>JUL 24 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DEPARTMENT OF HEALTH

OFFICE

Office of the Surgeon General

Public Health Service

Division of Field Operations, Bureau of Epidemiology and Prevention Control

Washington, D.C. 20492

Telephone (202) 692-6000

Teletype (202) 692-6000

Mail Stop 100, Washington, D.C. 20492

Post Office Box 100, Washington, D.C. 20492

Contract Office, 1000 North 17th Street, Arlington, Virginia 22209

Contract Office, 1000 North 17th Street, Arlington, Virginia 22209

09828

CERTIFICATE OF DEATH

09833

| | | | |
|---|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> | | c. LENGTH OF STAY IN 1b <u>151</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u> | | d. STREET ADDRESS <u>9802 Culver St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Carlos</u> First <u>F.</u> Middle <u>Noyes</u> Last | | 4. DATE OF DEATH <u>July</u> Month <u>2</u> Day <u>19</u> Year <u>67</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-18-1886</u> |
| 9. AGE (In years lost birthday) <u>81</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>2</u> Days <u>19</u> IF UNDER 24 HRS. Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Controller of Baltimore</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRY</u> | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>New York</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Locomotive Works</u> <u>Franklin F. Noyes</u> | | 14. MOTHER'S MARDEN NAME <u>Harriet Phillips</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>16 3-09-4907</u> | |
| 17. INFORMANT <u>Admission Discharge Record</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Arteriosclerotic Heart Disease</u>
DUE TO (b) <u>Abdominal aortic aneurysm</u>
DUE TO (c) <u>Esophageal achalasia</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchitis + emphysema</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u> | |
| 20c. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20e. (City or town) | | 20f. (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>64</u> , to <u>July 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>June 18</u> , 19 <u>67</u> , and that death occurred at <u>7:20</u> A.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Albert H. Orolman</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. OROLLMAN, M.D.</u> | | 22d. ADDRESS <u>1106 SPRING ST. SILVER SPRING, MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u> | 23b. DATE THEREOF <u>7-3-67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u> | 23d. LOCATION (City or Town) (County) (State) <u>Suitland Prince Georges Md.</u> |
| 24. FUNERAL DIRECTOR <u>Robert A. Pumphrey F.H.</u> | | ADDRESS <u>7557 Wise Ave. Beth Md.</u> | 25a. REC'D BY REGISTRAR <u>JUL 6 1967</u> DATE |
| | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | |

MEDICAL CERTIFICATION

Released subject by Medical Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

6520

CERTIFICATE OF DEATH

09829

09835

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY St. Marys | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN lb
25 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
483 Chinlee Drive | |
| 3. NAME OF DECEASED
(Type or print) James O'CONNOR, JR. | | 4. DATE OF DEATH
Month July Day 10 Year 19 67 | |
| 5. SEX
Male | 6. COLOR OR RACE
Cauc. | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
May 13, 1935 |
| 9. AGE (In years lost birthday) yrs.
32 | | IF UNDER 1 YEAR Months Days Hours Min.
IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U. S. Navy | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
Orange, New Jersey | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
James Francis O'Connor | | 14. MOTHER'S MAIDEN NAME
Dorothy Egan | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
yes 1955-1966 | | 16. SOCIAL SECURITY NO.
144-26-9900 | |
| 17. INFORMANT
Mrs. Arlene O'Connor, 483 Chinlee Drive | | Address New Jersey | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Embryonal Carcinoma right testicle with multiple metastases.
DUE TO (b)
DUE TO (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
ot work ot work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | | |
| 21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 15, 1967 to July 10, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on July 10, 1967 , and that death occurred at 620P M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>P. B. Blanchard</i> | | 22b. DATE SIGNED
12 July 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
P. B. Blanchard, M. D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial-transit 7-17-67 | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY
Arlington Natl Cem. | | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia | |
| 24. FUNERAL DIRECTOR
Robert A. Pumphrey Funeral Home, 7557 Wisconsin Ave., Bethesda, Md. | | 25a. REC'D BY REGISTRAR
JUL 19 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

fatigue level

Figure 1

• **2010**

၁၆၆

2000

James R. Smith, O'Donnell

0-27896-1-0

REF. 20 7004

[illegible]

21 5005

Of 2100

• • • • •

Robert A. Fungberg, Director

• • • • •

09830

CERTIFICATE OF DEATH

09834

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DR. REAP, MED. EXAM., NOTIFIED AND APPROVED. JGS.

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Chevy Chase | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
4701 Willard Avenue | | d. STREET ADDRESS
4701 Willard Avenue | |
| 3. NAME OF DECEASED
(Type or print) RUTH ELIZABETH OCHS | | 4. DATE OF DEATH
Month JULY Day 23 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
7-14-1903 |
| 9. AGE (In years last birthday) 64 yrs. | | 10. IF UNDER 1 YEAR
Months 15 Days 1 Hours 1 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Secretary | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Gov't. | |
| 11. BIRTHPLACE (County & State, or foreign country)
Virginia | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Adolph Volk | | 14. MOTHER'S MAIDEN NAME
Mamie Johnson | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO.
577-60-0352 | |
| 17. INFORMANT
Karl W. Ochs-See Item #2. | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Generalized Carcinomatosis.
DUE TO
(b) 1992
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. 19 p.m. | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (1) (this hospital) attended the deceased from July , 19 66 to July , 19 67 , that (1) (we) last saw the deceased alive on July 18 , 19 67 , and that death occurred at 7:40 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
James R. Coleman M.D. | | 22b. DATE SIGNED
July 23, 1967 | |
| 22c. PHYSICIAN'S NAME (Type)
JAMES R. COLEMAN | | 22d. ADDRESS
9241 COLUMBIA BLVD SILVER SPRING, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-26-1967 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Suitland, Md. |
| 24. FUNERAL DIRECTOR
Joseph Gawler's Sons, Inc. | | 25. REGISTAR'S SIGNATURE
Charles Judge | |

1992-1993

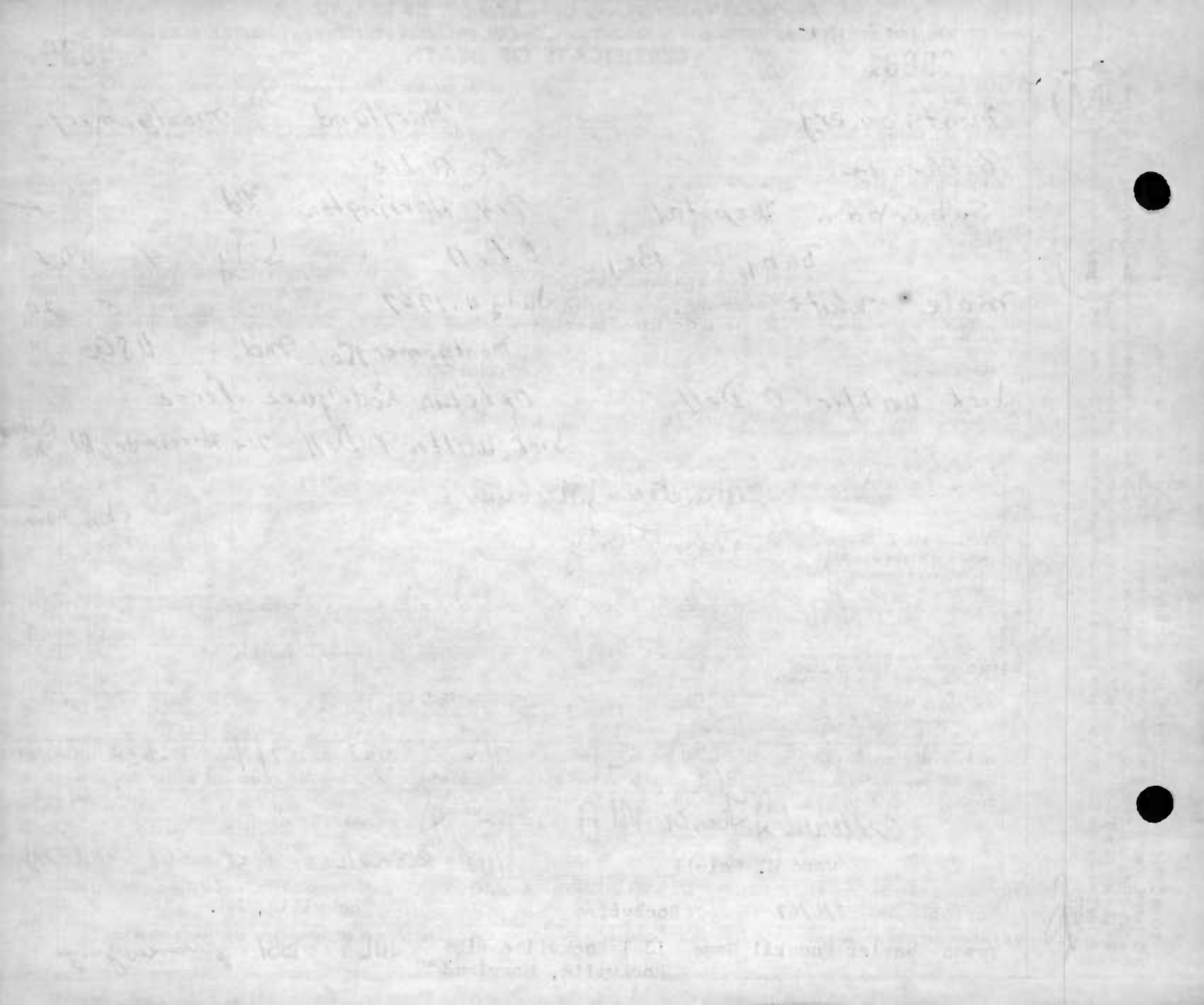
23-1-2005 10:05:45

• • •

TO HOSPITAL: The law requires that the death certificate be executed 24 hours after death. Page 4 is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

| | | | |
|--|--|---|--|
| 09831 | | 09836 | |
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>
c. LENGTH OF STAY IN lb
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Suburban Hospital</u> | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>
d. STREET ADDRESS <u>714 Harrington Rd.</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Baby Boy O'Dell</u> | | 4. DATE OF DEATH <u>July 4 1967</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>July 4, 1967</u> |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 9b. AGE (In years last birthday) <u>5</u> <u>20</u> MONTHS <u>5</u> DAYS <u>20</u> HOURS <u>20</u> MIN. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co., Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Jack Walter O'Dell</u> | | 14. MOTHER'S MAIDEN NAME <u>OpheLia Rodriguez Perez</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Jack Walter O'Dell</u> | | Address <u>714 Harrington Rd. Rockville, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uterectasis, Prematal</u>
7625 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Prematurity</u>
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH <u>5 hrs 20 mins</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> , 19 <u>67</u> to <u>7/4</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/4</u> , 19 <u>67</u> , and that death occurred at <u>1:30</u> PM, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Edward J. Feioli MA</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) <u>Edward J. Feioli</u> | | 22d. ADDRESS <u>11125 ROCKVILLE PIKE, ROCKVILLE, MD</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 23b. DATE THEREOF <u>7/6/67</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u> | 23d. LOCATION (City, town or county) (State) <u>Rockville, Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u> | | 25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |



09832

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

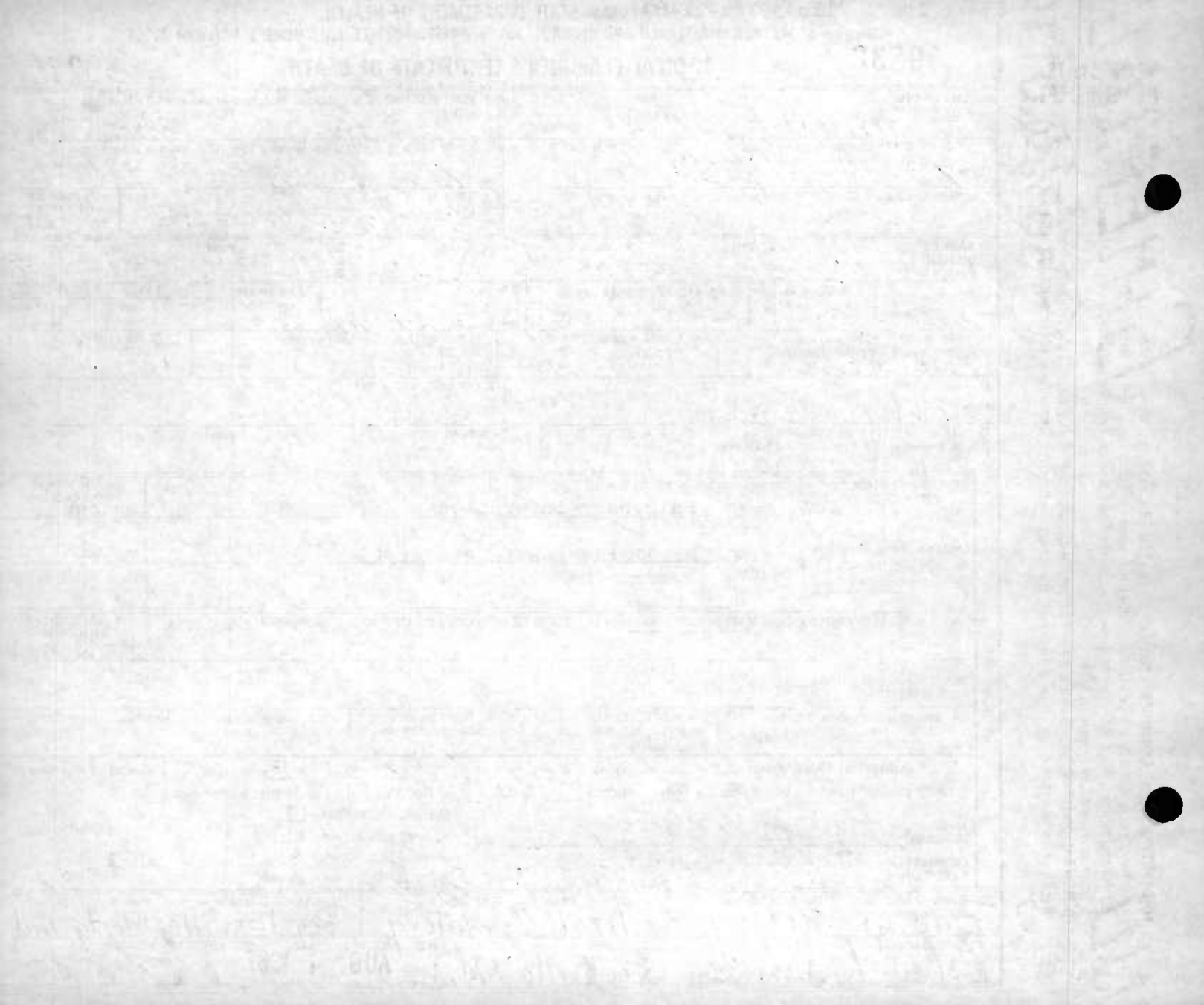
09837

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <u>Poolesville</u> | | c. CITY OR TOWN (If outside corporate limits; write RURAL and give nearest town) <u>Poolesville</u> 15.1 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) | | d. STREET ADDRESS <u>Cat tail Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Clarence Owens</u> | | 4. DATE OF DEATH <u>July 30</u> 19 <u>67</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 24 1899</u> 67 |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 12. FATHER'S NAME <u>Solomon Owens</u> | | 13. MOTHER'S MAIDEN NAME <u>Sally Davis</u> | |
| 14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 15. SOCIAL SECURITY NO. | |
| 16. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary infarction</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Mural thrombosis Rt. atrium</u>
DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
Years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>John S. Ryer</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>John S. Ryer</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22. DATE SIGNED <u>7/30/67</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 23b. DATE THEREOF <u>8/3/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Elizah Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Poolesville Montg, Md</u> | |
| 24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> | | ADDRESS <u>Rockville, Md.</u> | |
| 25a. REC'D BY REGISTRAR <u>AUG 7 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u> | |



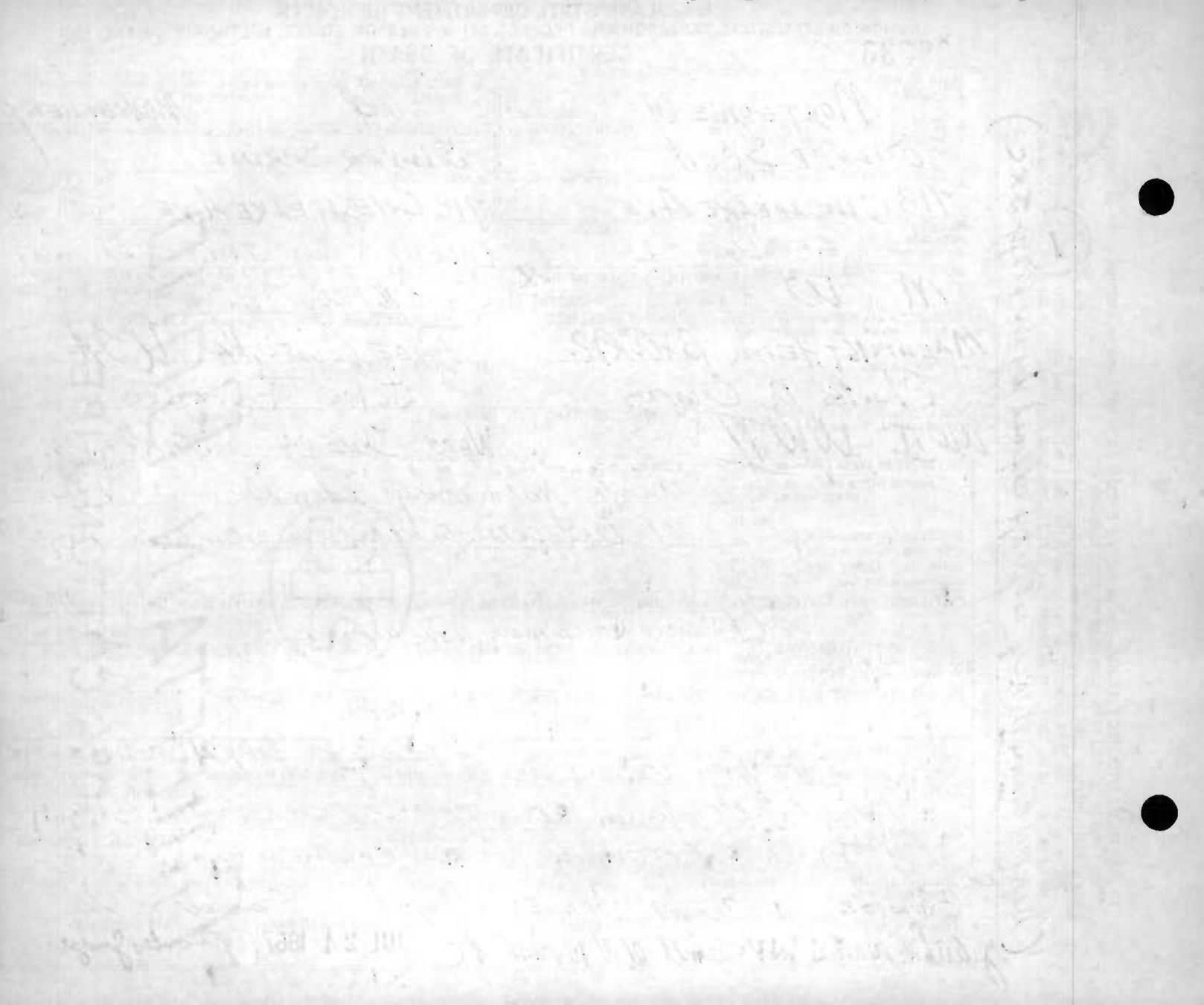
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in for the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove design papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

C. Rep. med. Exam. M. Rep. signed, & cleared by M. Rep. J.R.C.

MEDICAL CERTIFICATION

| DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
|---|--|---------------------------|--|--|--|---|--|--|--|---|--|
| 09833 | | | | | | | | | | | |
| 09833 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>MONTGOMERY</u> | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> 15.1 | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>713 CHESAPEAKE AVE</u> | | | | | | d. STREET ADDRESS <u>713 CHESAPEAKE AVE</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>GEORGE L OWENS</u> | | | | | | 4. DATE OF DEATH <u>JULY 21 1967</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Sept. 16, 1900</u> | | 9. AGE (in years last birthday) <u>66</u> yrs. | | 10. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MACHINIST HELPER</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>B & O R.R.</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Page County, VA</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>CHARLES D OWENS</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Julia BURACKER</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u> | | | | 16. SOCIAL SECURITY NO. <u>WW II</u> | | 17. INFORMANT <u>WARD OWENS</u> Address <u>Stanley, VA.</u> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u>
4221
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u>
DUE TO (c) <u>10 yrs.</u> | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pulmonary emphysema</u> | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (1) (this hospital) attended the deceased from <u>Sept 1964</u> to <u>July 21, 1967</u> , that (1) (we) last saw the deceased alive on <u>July 10 1967</u> , and that death occurred at <u>7:21 AM</u> , from the causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE <u>James R. Coleman M.D.</u> | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>July 21, 1967</u> | | | |
| 22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u> | | | | | | 22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING MD</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City, town or county) (State) | | | | | |
| <u>Burial</u> | | <u>7/23/67</u> | | <u>GRAVES Chapel</u> | | <u>Stanley, VA</u> | | | | | |
| 24. FUNERAL DIRECTOR <u>J. Arthur Walters, 237 Carroll Rd N.W. Wash. DC</u> | | | | | | 25a. REC'D BY REGISTRAR <u>JUL 24 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u> | | | |



09834

CERTIFICATE OF DEATH

09839

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Virginia b. COUNTY ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda (rural) | | c. LENGTH OF STAY IN lb
39 days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Naval Hospital | | d. STREET ADDRESS
Quarters 2965-A | |
| 3. NAME OF DECEASED
(Type or print)
Connie Sue PACK | | 4. DATE OF DEATH
Month July Day 7 Year 19 67 | |
| 5. SEX
Female | 6. COLOR OR RACE
Cauc | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
April 2, 1967 |
| 9. AGE (In years last birthday) yrs.
3 | | IF UNDER 1 YEAR: Months 3 Days 96 Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
N/A | | 10b. KIND OF BUSINESS OR INDUSTRY
N/A | |
| 11. BIRTHPLACE (County & State, or foreign country)
Quantico, Virginia | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Wallace L. Pack | | 14. MOTHER'S MAIDEN NAME
Lillian Killinger | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
N/A | |
| 17. INFORMANT
Quantico | | Address Virginia | |
| S/SGT Wallace L. Pack, USMC, Quarters 2965-A | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
2021 Letterer-Siwe's Disease
IMMEDIATE CAUSE (a) DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that 21 (this hospital) attended the deceased from May 29 , 19 67 , to July 7 , 19 67 , that 21 (we) last saw the deceased alive on July 7 , 19 67 , and that death occurred at 430A M, from causes on and on the date stated above. | | | |
| 22a. SIGNATURE
Jerry J. Tomasovic | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type)
Jerry J. Tomasovic, M.D. | | 22d. ADDRESS
Naval Hospital, Bethesda, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7-11-67 | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | 23d. LOCATION (City or Town) (County) (State)
Arlington, Virginia |
| 24. FUNERAL DIRECTOR Robert A. Pumphrey | | 25a. REC'D BY REGISTRAR JUL 13 1967 | |
| Funeral Home, 7557 Wisconsin Ave., Bethesda, Md. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Funeral Home, 1237 Wisconsin Ave., Bethesda, Md.

Robert A. Thompson

Arlington National

Arlington, Virginia

July 5, 1967

Naval Hospital, Bethesda, Md.

July 7

July 23

July 23

July 1

x

09835

09840

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring, Md.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Silver Spring</u> 151 | |
| c. LENGTH OF STAY IN 1b
<u>2 1/2 yrs.</u> | | d. STREET ADDRESS <u>2902 Sheraton St.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Montgomery Cancer Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>Jessie Ross Pancoast</u> | | 4. DATE OF DEATH
Month Day Year
<u>7-21 1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-15-1874</u> |
| 9. AGE (In years last birthday)
<u>93</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Teacher</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME
<u>Hon. Nathan Ross</u> | | 14. MOTHER'S MAIDEN NAME
<u>Burgess</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>219-54-737351</u> | |
| 17. INFORMANT
<u>Mr. Ross Pancoast</u> | | Address <u>2902 Sheraton St. Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u>
DUE TO
(b) <u>Thrombolytic arteriosclerosis</u>
DUE TO
(c) <u>24 hrs</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>None</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>2-24</u> , 19 <u>56</u> , to <u>7-21</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7-21</u> , 19 <u>67</u> , and that death occurred at <u>4:10 A.M.</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>John S. Rogers, MD</u> | | 22b. DATE SIGNED
<u>7-21-67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>John S. Rogers, MD</u> | | 22d. ADDRESS
<u>1818 Semin 2nd Rd. Silver Spring, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>7/25/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Hartford Rd Cem.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Hartford Rd Baltimore Md.</u> |
| 24. FUNERAL DIRECTOR
<u>W.W. Chombar Co.</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 27 1967</u> | |
| ADDRESS
<u>1400 Chapin St. Washington, D.C.</u> | | 25b. REGISTRAR'S SIGNATURE
<u>James Judge</u> | |

STATE OF MONTANA

1907

TO THE HONORABLE COMMISSIONER OF THE LAND OFFICE
CARE OF THE LAND OFFICE
HELENA, MONTANA

SIR:

I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. H. [Signature]

Very truly yours,
J. H. [Signature]

1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove section papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09836

CERTIFICATE OF DEATH

09841

| | | | |
|---|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY MONTGOMERY MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE MARYLAND b. COUNTY MONTGOMERY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
BETHESDA, RURAL | | c. LENGTH OF STAY IN lb
3 days | |
| c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
CHEVY CHASE | | d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
U.S. NAVAL | |
| d. STREET ADDRESS
3317 W. COQUELIN TERR. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) CATHERINE COCKRILLE PANKEY | | 4. DATE OF DEATH
Month JULY Day 24 Year 19 67 | |
| 5. SEX
FEMALE | 6. COLOR OR RACE
CAUC | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
JAN. 8, 1914 |
| 9. AGE (In years last birthday) yrs.
53 | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY
- | |
| 11. BIRTHPLACE (County & State, or foreign country)
WASHINGTON, D.C. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Clarence FRANK COCKRILLE | | 14. MOTHER'S MAIDEN NAME
Rosa Lee Groves | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
NO | | 16. SOCIAL SECURITY NO.
NONE | |
| 17. INFORMANT
RUSSELL G. PANKEY | | Address CHEVY CHASE, MD.
3317 W. COQUELIN TERR. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
171X
IMMEDIATE CAUSE (a) CARCINOMA OF THE CERVIX (EPIDERMOID)
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Nat While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from JULY 21, 19 67 , to JULY 24, 19 67 that (I) (we) last saw the deceased alive on JULY 24, 19 67 , and that death occurred at 4:40 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Neil D. Jackson | | 22b. DATE SIGNED
7/24/67 | |
| 22c. PHYSICIAN'S NAME (Type)
NEIL D. JACKSON | | 22d. ADDRESS
US NAVAL HOSPITAL, BETHESDA, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY
ARLINGTON NAT'L CEMETERY | 23d. LOCATION (City or Town) (County) (State)
ARLINGTON VA. |
| 24. FUNERAL DIRECTOR
Joseph Gawler & Sons Funeral Home | | 25a. REC'D BY REGISTRAR
JUL 31 1967 | |
| Address
5130 Wisconsin Ave., N.W. Washington, D.C. | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

STATE OF TEXAS

John Lee Groves

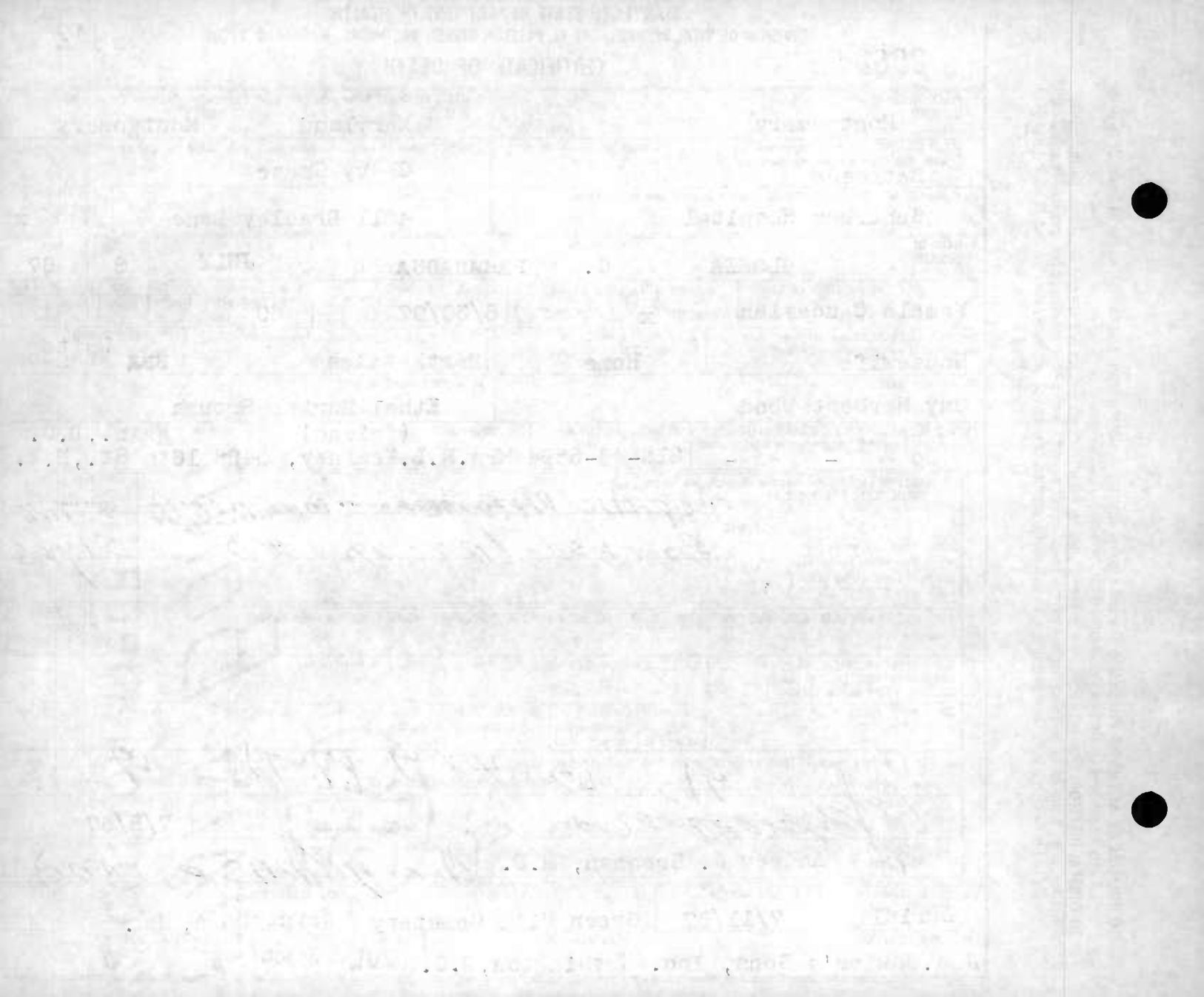
George Decker & Sons, Mineral Water
Bottling Co., P.O. Box 1000, Houston, Texas

CERTIFICATE OF DEATH

| | | | |
|---|--------------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bethesda | | c. LENGTH OF STAY IN lb
Chevy Chase 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Suburban Hospital | | d. STREET ADDRESS
4011 Bradley Lane | |
| 3. NAME OF DECEASED
(Type or print) GLORIA C. PARANAGUA | | 4. DATE OF DEATH
Month JULY Day 8 Year 1967 | |
| 5. SEX
Female | 6. COLOR OR RACE
Caucasian | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
8/30/97 |
| 9. AGE (In years last birthday)
69 yrs. | | 10. IF UNDER 1 YEAR
Months 8 Days 19 Hours 67 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 11. BIRTHPLACE (County & State, or foreign country)
North Wales | | 12. CITIZEN OF WHAT COUNTRY
United Kingdom | |
| 13. FATHER'S NAME
Guy Herbert Wood | | 14. MOTHER'S MAIDEN NAME
Ethel Murial Brough | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
216-46-5594 | |
| 17. INFORMANT (friend)
Mrs. R.L. Kearney | | Address Wash., D.C. 3426 16th St., N.W. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Hepatic Metastatic Carcinoma
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Breast Carcinoma
DUE TO
(c) 5 yrs | | | INTERVAL BETWEEN ONSET AND DEATH
2 mo |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from MAY 1967 to 7/8 , 1967 that (I) (we) last saw the deceased alive on 7/7 1967, and that death occurred at 6 PM , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
Andrew J. Brennan, M.D. | | 22b. DATE SIGNED
7/8/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Andrew J. Brennan, M.D. | | 22d. ADDRESS
Chevy Chase, Md | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7/11/67 | 23c. NAME OF CEMETERY OR CREMATORY
Green Hill Cemetery | 23d. LOCATION (City or Town) (County) (State)
Waynesboro, Pa. |
| 24. FUNERAL DIRECTOR
Jos. Gawler's Sons, Inc. Washington, D.C. | | 25a. REC'D BY REGISTRAR
JUL 13 1967 | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



09836

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09843

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|--|--|-------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> | | | c. LENGTH OF STAY IN 1b <u>1 HR</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> 151 | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u> | | | | d. STREET ADDRESS <u>METROPOLITAN DRIVE RD</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>MAURICE WILBERT PARIS</u> | | | | 4. DATE OF DEATH <u>JULY 25 1967</u> | | | |
| 5. SEX <u>MALE</u> | | 6. COLOR OR RACE <u>NEGRO</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>7/27/1914</u> 52 yrs. | |
| 9. AGE (In years last birthday) <u>52</u> | | 10. IF UNDER 1 YEAR Months Days | | 11. IF UNDER 24 HRS. Hours Min. | | 12. IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Messenger U.S. Gov</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov</u> | | 11. BIRTHPLACE (State or foreign country) <u>STAUNTON, VA.</u> | |
| 13. FATHER'S NAME <u>CHARLES PARIS</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> | | 16. SOCIAL SECURITY NO. <u>ARMY</u> | | 17. INFORMANT <u>Wife - Anna Paris</u> | | Address <u>Same as above</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4201 Coronary Thrombosis. Acute.</u>
DUE TO (b) <u>CardioVascular Disease -</u>
DUE TO (c) <u>Years</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>2 hr</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>John S. Ball</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22. DATE SIGNED <u>7/25/67</u> | |
| EXAMINER'S NAME (Type) <u>Robert L. Sworlan</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | Address (Street, city, town, or county) <u>Rockville, Md.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>July 29, 1967</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Emory Grove, Montg. Md.</u> | |
| 24. FUNERAL DIRECTOR <u>Robert L. Sworlan</u> | | | | 25a. REC'D BY REGISTRAR <u>JUL 27 1967</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

| MARYLAND STATE DEPARTMENT OF HEALTH | | | |
|---|-------------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | |
| CERTIFICATE OF DEATH | | | |
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Olney | | c. LENGTH OF STAY IN lb
3wks 3days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Montgomery General | | d. STREET ADDRESS
3632 Gleneagles Dr., Apt 8G2 | |
| 3. NAME OF DECEASED
(Type or print)
Adah Florence Patterson | | 4. DATE OF DEATH
Month July Day 12 Year 19 67 | |
| 5. SEX
F | 6. COLOR OR RACE
W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
3-17-91 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
own home | 9. AGE (In years last birthday)
76 yrs. |
| 11. BIRTHPLACE (County & State, or foreign country)
Iowa | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
William H. Otto | | 14. MOTHER'S MAIDEN NAME
Emma Edgar | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
220-34-8577B | |
| 17. INFORMANT
Homer L Patterson 9700 Dyer St., El Paso, Texas | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bilateral Pulmonary Congestion
DUE TO (b) Rt. Heart Failure
DUE TO (c) Metastatic Ca of Liver, Primary site undetermined | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Refractory Anemia | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) (County) (State) | | 21. I certify that (I) (this hospital) attended the deceased from June 17 , 19 67 , to July 12 , 19 67 , that (I) (we) last saw the deceased alive on July 12 , 19 67 , and that death occurred 2:26A M, from causes and on the date stated above. | |
| 22a. SIGNATURE
Richard A. Yates | | 22b. DATE SIGNED
7/12/67 | |
| 22c. PHYSICIAN'S NAME (Type)
Richard A. Yates | | 22d. ADDRESS
Old Baltimore Rd., Olney, Md. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 23b. DATE THEREOF
7/15/67 | 23c. NAME OF CEMETERY OR CREMATORY
George Washington | 23d. LOCATION (City or Town) (County) (State)
Riggs Rd. Adelphi, Md. |
| 24. FUNERAL DIRECTOR
Warner E. Pumphrey, Inc. 8434 Ga. Ave., S.S., Md. | | 25a. REC'D BY REGISTRAR
DATE JUL 14 1967 | |
| 25b. REGISTRAR'S SIGNATURE
Charles J. Jagger | | | |

CERTIFICATE OF DEATH

County of ... State of ...

Deceased ...

Age ...

Sex ...

Date of Death ...

Place of Death ...

Signature of ...

Witness ...

...

...

...

...

...

...

...

...

...

...

...

...

...

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

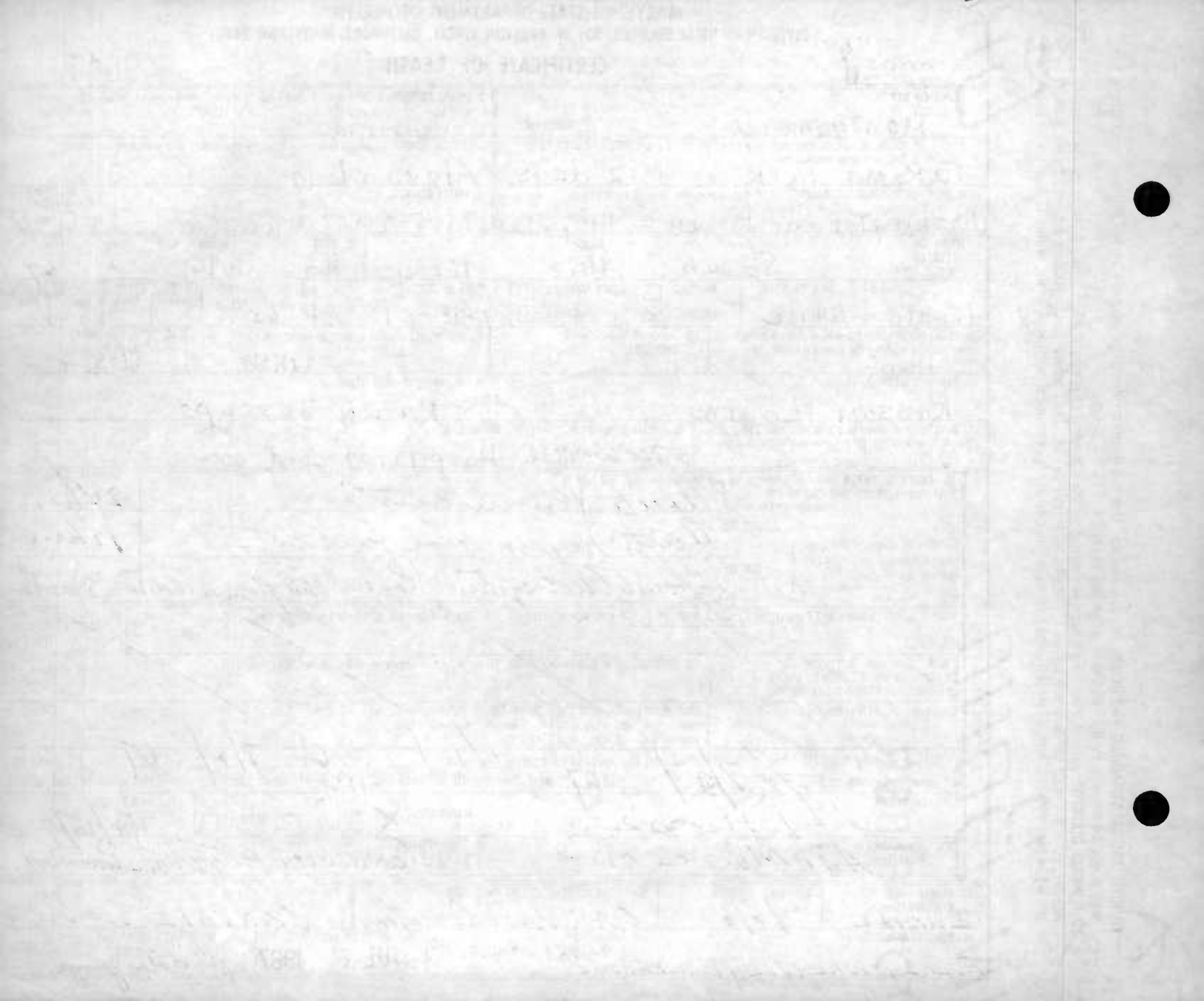
CERTIFICATE OF DEATH

09840

09845

| | | | |
|---|-------------------------------|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>Virginia</u> b. COUNTY <u>York</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u> 83.3 | |
| c. LENGTH OF STAY IN 1b <u>12 days</u> | | d. STREET ADDRESS <u>7805 Accotink Rd.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium & Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>Alma</u> Last <u>Perry</u> | | 4. DATE OF DEATH Month <u>July</u> Day <u>2</u> Year <u>1967</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>7-18-01</u> 65 yrs. |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 9b. KIND OF BUSINESS OR INDUSTRY | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (County & State, or foreign country) <u>W. Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u> | |
| 13. FATHER'S NAME <u>Ransom Louins</u> | | 14. MOTHER'S MAIDEN NAME <u>Nancy Jessups</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>578-30-9832</u> | |
| 17. INFORMANT <u>Hospital Record</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Pancreatitis</u>
DUE TO (b) <u>Acute Myocardial Infarction</u>
DUE TO (c) <u>Subacute Cholecystitis. Pancreatic Obstruction. Died 3 months</u> | | INTERVAL BETWEEN ONSET AND DEATH. <u>2 days</u>
<u>12 hrs.</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>1/16/67</u> , 19 <u>66</u> to <u>7/2/67</u> , that (I) (we) last saw the deceased alive on <u>7/2/67</u> , 19 <u>67</u> , and that death occurred at <u>4:23</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>H. J. Morse</u> | | 22b. DATE SIGNED <u>7/2/67</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>H. J. Morse MD</u> | | 22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 23b. DATE THEREOF <u>7/6/67</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>CAK VALE CEMETERY</u> | | 23d. LOCATION (City or Town) (County) (State) <u>CAK VALE W. Va</u> | |
| 24. FUNERAL DIRECTOR <u>EVERLY-WHEATLEY FUNERAL HOME</u> | | 25a. REC'D BY REGISTRAR <u>JUL 7 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1
M

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09841

CERTIFICATE OF DEATH

09846

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Chevy Chase</u> 151 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>70 Suburban Hospital</u> | | d. STREET ADDRESS
<u>16 PRIMROSE STREET</u> | |
| 3. NAME OF DECEASED (Type or print)
First Middle Last
<u>GRACE Auglier PETTIN</u> | | 4. DATE OF DEATH
Month Day Year
<u>July 1 1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>9/8/1886</u> |
| 9. AGE (In years last birthday) yrs.
<u>80</u> | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>At Home</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>New York, New York</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Charles Auglier</u> | | 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>NONE</u> | |
| 17. INFORMANT
<u>Emil Joseph Pettin</u> | | Address <u>16 PRIMROSE ST. CACAMID</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, TERMINAL</u>
DUE TO (b) <u>GANGRENE LEFT LOWER EXTREMITY</u>
DUE TO (c) <u>PERIPHERAL VASC. DISEASE</u>
<u>OBLITERATIVE ARTERIOSCLEROTIC</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 DAYS</u>
<u>8 DAYS</u>
<u>5 YEARS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
<u>ANEURYSM ASCENDING AORTA</u> | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.
<u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 30, 1967</u> , to <u>JULY 1, 1967</u> , that (I) (we) last saw the deceased alive on <u>JUNE 30, 1967</u> , and that death occurred at <u>3:30A</u> M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>Robert G. Angle</u> | | 22b. DATE SIGNED
<u>July 1, 1967</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>Robert G Angle</u> | | 22d. ADDRESS
<u>5009 Del Ray Ave Bethesda, Md</u> | |
| 23a. BURIAL, CREMATION, or other disposition
<u>Burial</u> | 23b. DATE THEREOF
<u>7-3-67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>Robert A. Humphrey</u> | | 25. REC'D BY REGISTRAR
<u>JUL 6 1967</u> | |
| 25a. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | 25b. REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | |
|---|--|--|--|
| 09842 | | 09847 | |
| 1. PLACE OF DEATH
a. COUNTY
Montgomery
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
c. LENGTH OF STAY IN 1b
17 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington Sanitarium and Hospital | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE
Maryland
b. COUNTY
Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Takoma Park
d. STREET ADDRESS
617 Elm Avenue
e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print)
Lloyd H Poynter | | 4. DATE OF DEATH
Month July Day 19 Year 1967 | |
| 5. SEX
male | | 6. COLOR OR RACE
white | |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
12-20-93 | |
| 9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Retired | | 9b. KIND OF BUSINESS OR INDUSTRY
Kentucky | |
| 10a. BIRTHPLACE (County & State, or foreign country)
Kentucky | | 10b. CITIZEN OF WHAT COUNTRY?
America | |
| 11. FATHER'S NAME
Thomas Poynter | | 12. MOTHER'S MAIDEN NAME
Emily Payne | |
| 13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
Yes WW I Army | | 14. SOCIAL SECURITY NO.
1404-09-6837 | |
| 15. INFORMANT
Patient's chart | | 16. ADDRESS
Army | |
| 17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4200 Congestive heart failure
DUE TO (b) Arteriosclerotic heart disease
(c) and Pulmonary emphysema | | 18. INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Acute Gastric ulcer - Recent hemorrhage | | 19. WAS AUTOPSY PERFORMED?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from July , 19 65 , to 7/19 , 19 67 , that (I) (we) last saw the deceased alive on 7/18 , 19 67 , and that death occurred at 4:15 M, from causes and on the date stated above. | | | |
| 22a. SIGNATURE
John D. Griswold MD. | | 22b. DATE SIGNED
7/19/67 | |
| 22c. PHYSICIAN'S NAME (Type)
John D. Griswold MD. | | 22d. ADDRESS
4830 V. St NW, DC | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE THEREOF
7/21/67 | |
| 23c. NAME OF CEMETERY OR CREMATORY
BALTIMORE NATIONAL | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR
GASCH'S | | 25. REC'D BY REGISTRAR
JUL 21 1967 | |
| 25a. ADDRESS
HYATTSVILLE, MARYLAND | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

CERTIFICATE OF DEATH

12345

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]
PLACE OF BURIAL: [illegible]

SIGNATURE OF DECEASED: [illegible]
SIGNATURE OF WITNESS: [illegible]

DATE OF SIGNATURE: [illegible]
PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]
PLACE OF BURIAL: [illegible]

DATE OF SIGNATURE: [illegible]
PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]
PLACE OF BURIAL: [illegible]

DATE OF SIGNATURE: [illegible]
PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]
PLACE OF BURIAL: [illegible]

DATE OF SIGNATURE: [illegible]
PLACE OF SIGNATURE: [illegible]

DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]

09843

CERTIFICATE OF DEATH

09848

| | | | | | | | |
|---|-------------------------------|--|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Olney | | c. LENGTH OF STAY IN lb 16 days | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sandy Spring, Md. | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Montgomery General Hospital | | | | d. STREET ADDRESS Box 81 | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Bessie First Middle Last Pratt | | | | 4. DATE OF DEATH Month July Day 18 Year 1967 | | | |
| 5. SEX Female | 6. COLOR OR RACE Negro | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 8-6-92 | | 9. AGE (In years last birthday) 74 yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (County & State, or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME George Jackson | | | | 14. MOTHER'S MAIDEN NAME Margaret Hopkins | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4201 Congestive Heart Failure
DUE TO Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Arteriosclerotic Heart Disease
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive C-V Disease, 2 Grades Mellitus | | | | INITIAL BETWEEN ONSET AND DEATH 3 days 2 wks yrs | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from 6/17/67 to 7/18/67 , 19 67 , that (I) (we) last saw the deceased alive on 7/17/67 , and that death occurred at 6:15 am on 7/18/67 , from causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Dr. Charles Ligon | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED 7/18/67 | |
| 22c. PHYSICIAN'S NAME (Type) Dr. Charles Ligon | | | | 22d. ADDRESS Sandy Spring, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | | 23b. DATE THEREOF 7/22/67 | | 23c. NAME OF CEMETERY OR CREMATORY SANDY SPRING CEMETERY | | 23d. LOCATION (City or Town) (County) (State) SANDY SPRING, MONTG. MD. | |
| 24. FUNERAL DIRECTOR Robert L. Snowden | | | | ADDRESS ROCKVILLE, MD. | | 25a. REC'D BY REGISTRAR JUL 24 1967 | |
| | | | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09844

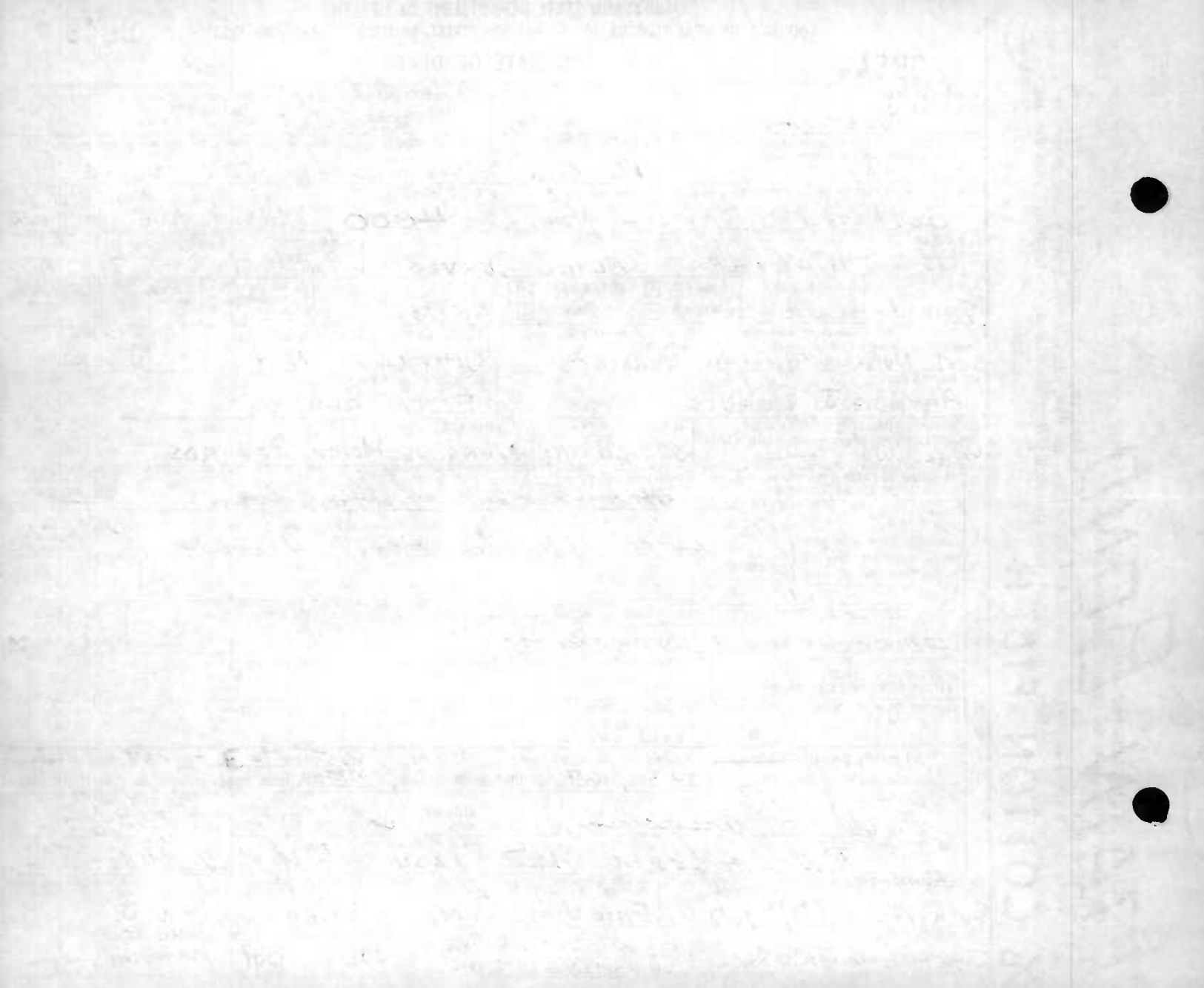
CERTIFICATE OF DEATH

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Montgomery</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>DE</u> b. COUNTY <u>1</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bethesda MD</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Washington D.C. 20016</u> | |
| c. LENGTH OF STAY IN lb
<u>1 1/2 day</u> | | d. STREET ADDRESS
<u>4000 Cathedral Ave. N.W.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Bethesda Silver Spring Nursing Home</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>MARGARET BLAKE PURVIS</u> | | 4. DATE OF DEATH
Month <u>7</u> Day <u>3</u> Year <u>1967</u> | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>Cauc.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>1-5-85</u> |
| 9. AGE (In years lost birthday)
<u>82</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Supt. Nursing Education</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>NURSING</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Water town N.Y.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>ARTHUR J. PURVIS</u> | | 14. MOTHER'S MAIDEN NAME
<u>ELLEN BLAKE</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>UNKNOWN</u> | | 16. SOCIAL SECURITY NO.
<u>579-60-6434</u> | |
| 17. INFORMANT
<u>Nursing Home Records</u> | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO
(c) <u> </u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
<u>Emphysema + Bronchitis</u> | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour a.m. <u> </u> p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>7-3-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MAY 30, 1967</u> , and that death occurred at <u>7:20 AM</u> , from causes and on the date stated above. | | | |
| 22a. SIGNATURE
<u>R.W. Lancevin</u> | | 22b. DATE SIGNED
<u>7/3/67</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>R.W. LANCEVIN, MD</u> | | 22d. ADDRESS
<u>1234 19th St. N.W. WASH. D.C.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | 23b. DATE THEREOF
<u>7/7/67</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>FAIRVIEW CEM.</u> | 23d. LOCATION (City or Town) (County) (State)
<u>RED BANK, N.J.</u> |
| 24. FUNERAL DIRECTOR
<u>JOSEPH GAWLER'S SONS</u> | | 25a. REC'D BY REGISTRAR
DATE <u>JUL 7 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>James J. Jones</u> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Medical Examiner with Green

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09845

09850

| | | | |
|--|--|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>MONTGOMERY</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>SILVER SPRING.</u> | | c. LENGTH OF STAY IN Tb
<u>3 MONTH.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>2105 GREENERY LANE Ap 302. SILVER SPR. MD.</u> | | d. STREET ADDRESS
<u>2105 Greenery Lane Ap 302 SS.</u> | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>GRACE ANDERSON QUINLAN.</u> | | 4. DATE OF DEATH
Month Day Year
<u>July 22 1967</u> | |
| 5. SEX
<u>FEMALE</u> | 6. COLOR OR RACE
<u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>November 12, 1906</u> |
| 9. AGE (In years lost, birthday)
<u>60</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min.
<u>8 10</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>HOUSE WIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>OWN HOME</u> | |
| 11. BIRTHPLACE (County & State, or foreign country)
<u>Chicago, Illinois</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA.</u> | |
| 13. FATHER'S NAME
<u>ANDREW Anderson</u> | | 14. MOTHER'S MAIDEN NAME
<u>Signe Pihlo</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
<u>No None</u> | | 16. SOCIAL SECURITY NO.
<u>218-56-5544</u> | |
| 17. INFORMANT
<u>William A. Quinlan Husband</u> | | Address
<u>2105 Greenery Lane Silver Spring, Md.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>MEDIASTINAL TUMOR.</u>
DUE TO (b) <u>CORONARY THROMBOSIS</u>
DUE TO (c) <u>POSSIBLE CEREBRAL EMBOLISM.</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 MONTHS</u>
<u>1-3 MONTHS</u>
<u>DAYS.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o.m. p.m. <u>19</u> | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
ot work ot work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 27</u> , 19 <u>67</u> , to <u>JULY 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JULY 25</u> , 19 <u>67</u> , and that death occurred at <u>8:30 P</u> M, from causes on and the date stated above. | | | |
| 22a. SIGNATURE
<u>Hugo G. Graziani, M.D.</u>
<u>for Dr. John Curry</u> | | 22b. DATE SIGNED
<u>7/22/67.</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>HUGO G. GRAZIANI, MD.</u> | | 22d. ADDRESS
<u>10101 GEORGIA AVE., S. S., MD.</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | 23b. DATE THEREOF
<u>July 26, 1967</u> | 23c. NAME OF CEMETERY OR CREMATORY
<u>Gate of Heaven Cemetery</u> | 23d. LOCATION (City or Town) (County) (State)
<u>Silver Spring, Maryland</u> |
| 24. FUNERAL DIRECTOR
<u>John B. Thomas, John B. Thomas, 8434 Georgia Avenue</u>
<u>Warner E. Pumphrey, Inc. Silver Spring, Md.</u> | | 25a. REGD BY REGISTRAR
<u>JUL 27 1967</u> | |
| 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | DATE | |

STATE OF NEW YORK

IN SENATE

JANUARY

1901

REPORT

OF THE

COMMISSIONERS

OF THE LAND OFFICE

AND

OF THE

MINES

AND

OF THE

WATER

RESOURCES

OF THE STATE

FOR THE YEAR

ENDING

DECEMBER

31, 1900

ALBANY:

WATKINS

PRINTED BY THE STATE PRINTING OFFICE

1901

107-1-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

| <div>#17, Film G496 6/28/76 kam MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>09846</div> <div>09851</div> | | | | | | | | | | | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY Montgomery MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Maryland b. COUNTY Montgomery | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | c. LENGTH OF STAY IN tb
20 years | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Silver Spring | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
11604 Georgia Avenue | | | | | | d. STREET ADDRESS
11604 Georgia Avenue | | | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) James Henry Quinn | | | | | | 4. DATE OF DEATH
Month July Day 23 Year 1967 | | | | | |
| 5. SEX
M | | 6. COLOR OR RACE
W | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
May 9, 1899 | | 9. AGE (In years last birthday)
68 yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Purchasing Agent | | | | 10b. KIND OF BUSINESS OR INDUSTRY
U.S. Govt. | | 11. BIRTHPLACE (County & State, or foreign country)
Conn. | | | 12. CITIZEN OF WHAT COUNTRY
U.S.A. | | |
| 13. FATHER'S NAME
James Quinn | | | | | | 14. MOTHER'S MAIDEN NAME
Louise Anger | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
Yes | | | | 16. SOCIAL SECURITY NO.
UN11 | | 17. INFORMANT (Wife)
Jacoba S. Quinn | | Address
11604 Georgia Avenue Silver Spring, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Inanition & Anemia
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cancer of Bladder with Metastases
DUE TO
(c) 4 years | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. 19 | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work at work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 1963 , 19 to Present , 19, that (I) (we) last saw the deceased alive on 7-23 19 67 , and that death occurred at 5:30 P M, from causes and on the date stated above. | | | | | | | | | | | |
| 22a. SIGNATURE
Morris Perry | | | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
7-23-67 | | | |
| 22c. PHYSICIAN'S NAME (Type) Morris Perry, M.D. | | | | | | 22d. ADDRESS
11602 Georgia Avenue, Silver Spring, Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
July 27, 1967 | | 23c. NAME OF CEMETERY OR CREMATORY
Parklawn Cemetery | | | | 23d. LOCATION (City or Town) (County) (State)
Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR
John B. Thomas | | | | | | ADDRESS
8434 Georgia Avenue | | 25a. REC'D BY REGISTRAR
Warner E. Humphrey, Inc. | | 25b. REGISTRAR'S SIGNATURE
Warner E. Humphrey | |
| DATE
JUL 31 1967 | | | | | | | | | | | |

2025

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25

10/10/25